

***Evaluation of a
Psychoeducational Programme
Teaching Emotional
Discrimination and Management
to Treat
Binge Eating Disorder.***

***A THESIS SUBMITTED IN FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF***

MASTER OF ARTS IN PSYCHOLOGY

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Dear Courtney

The Human Ethics Committee advises that your research proposal "**Evaluation of a psychoeducational programme teaching emotional discrimination, recognition and management to treat binge eating disorder**" has been considered and approved.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Isobel S Phillips'. The signature is written in a cursive style with a large, flowing 'I' and 'P'.

Isobel S Phillips
Secretary

EVALUATION OF A PSYCHOEDUCATIONAL PROGRAMME TEACHING EMOTIONAL DISCRIMINATION AND MANAGEMENT TO TREAT BINGE EATING DISORDER.

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ABSTRACT

Much current research indicates that there is a strong emotional component in the etiology and maintenance of binge eating disorder. In particular, the affect regulation model argues that binge eating is a way of coping with emotional distress. Unfortunately, the majority of current treatments for binge eating disorder fail to address the link between binge eating and aversive negative affect. One exception is dialectical behaviour therapy (DBT), a treatment recently adapted to treat binge eating disorder, but one that may require up to ten months of treatment. A psychoeducational programme modelled on the affect regulation paradigm, employing techniques similar to those used in DBT to improve emotional intelligence, was given to 11 participants. A multiple baseline design was used across participants in groups. The first group, consisting of five women, was followed two weeks later by a second group, consisting of four women. The last group, consisting of two women, started four weeks after the first and two weeks after the second. The programme included sessions on emotional discrimination and management, relaxation techniques, problem solving skills, and assertion training. Ten weekly sessions, each of up to two hours duration, were provided. Data was obtained from a range of self-report questionnaires, self-monitoring, and from an ATSS procedure. The results showed that the programme was effective in reducing binge eating and related symptomatology. Improvements were found on several measures, particularly the Binge Eating Scale (BES), and the Questionnaire on Eating and Weight Patterns (QEWP). Although emotional intelligence did not increase to a statistically significant level, the means from pre to post-intervention indicated their emotional intelligence improved considerably, and their alexithymia scores decreased significantly. Implications and limitations of the study are considered, and suggestions are made for future research.

CHAPTER 1: INTRODUCTION

This thesis reports a study of binge eating disorder, which affects many men and women of differing ages. Although binge eating disorder has been the topic of much research, there are still many issues that need addressing. The thesis will begin with a review of the literature on binge eating disorder, with particular reference to the influence of aversive emotional states. As emotional distress has been linked to binge eating disorder, this thesis will evaluate the effectiveness of teaching emotional discrimination and management to those with binge eating problems.

AN OVERVIEW OF BINGE EATING DISORDER

DIAGNOSTIC CRITERIA

Binge eating disorder (BED) was first recognised by Stunkard in 1959. The American Psychiatric Association has defined binge eating disorder as “recurring episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.” To meet the criteria for a diagnosis of BED, the person must engage in binge eating episodes two times per week on average, for at least six months, and must have a marked distress about their eating behaviour (DSM-IV; American Psychiatric Association; 1994). Other symptoms include consuming an objectively large amount of food in a discrete period of time, eating in the absence of hunger, loss of control over eating, eating until uncomfortably full, and an absence of compensatory behaviours such as vomiting, laxative abuse, and over exercising (APA; 1994). In addition, those with binge eating disorder frequently eat alone due to embarrassment over how much they are eating, and feel disgusted with themselves, depressed, and/or guilty after a binge episode (APA; 1994). Despite the fact that it is

widely accepted as a separate and distinct eating disorder from bulimia nervosa and anorexia nervosa and has its own defining characteristics, BED remains in the Diagnostic and Statistical Manual of Mental Disorders in an appendix under the heading “eating disorder not otherwise specified.” (APA, 1994).

WHAT IS A BINGE?

Initially, the definition of a binge episode for both bulimia nervosa and binge eating disorder was the rapid consumption of an objectively large amount of food in a discrete period of time (Johnson, Boutelle, Torgrud, Davig, & Turner, 2000; Beglin & Fairburn, 1992), however, recent research has documented that binge episodes are not that easily defined. Researchers have since found that individuals suffering from BED do not always consume an objectively large amount of food during a binge (Johnson et al., 2000; Pratt, Niego, & Agras, 1998; Telch & Agras, 1996). Moreover, binge episodes can vary in their duration, ranging from minutes to an all day binge (e.g., Marcus, 1996; Touyz, 1995; Abraham & Beumont, 1982). In fact, when defining an eating episode as a binge based on quantity of food consumed and the duration, there is little agreement between binge eaters, peers, and dietitians (Johnson, Carr-Nangle, Nangle, Antony, & Zayfort, 1997; Schlundt & Johnson, 1990). Moreover, research has demonstrated that individuals with BED are biased towards labeling their eating episodes as a binge (Wilson & Vitousek, 1999; Williamson, Gleaves, & Lawson, 1991; Rossiter & Agras, 1990). In addition, whether or not an individual labels their eating as a binge may depend on their emotional state before and after the binge. Some studies have shown that negative mood, which is often associated with perceived loss of control, may bias the individual towards labeling their eating as a binge (Johnson et al., 2000; Telch et al., 1996; Beglin et al., 1992; Crowther, Lingseiler, & Stephens, 1984).

Recent studies have also documented that for those suffering from BED, a binge is almost always accompanied by subjective distress. Such distress is born of a perceived lack of control; and the fear of not being able to resist eating or of not being able to stop

once they have begun, and of violating self-imposed expectations for eating (APA; 1994; Wilson et al., 1993; Rossiter et al., 1990). Thus, perceived loss of control during a binge episodes is required for a diagnosis of BED (APA; 1994).

In terms of the actual content of binge episodes, it has been found that there are differences in the binges of individuals with binge eating disorder and bulimia nervosa. The binges of those with bulimia nervosa are higher in carbohydrates and sugars (Fitzgibbon & Blackman, 2000; Yanovski, Leet, Yanovski, Flood, Gold, Kissileff, & Walsh, 1992), which can be attributed to their otherwise avoiding “taboo” foods that contain large amounts of sugar and carbohydrates (but see Abraham & Beumont, 1982). Bulimic individuals are thought to crave such foods during binges due to having restricted these foods during inter-binge periods (Fitzgibbon et al., 2000). For individuals with BED, the food consumed during a binge often reflects that which would be consumed during a typical meal (Fitzgibbon et al., 2000), and the amount of food eaten resembles that of equal weight non-bingers (Devlin, 1996). Thus, the food consumed by those with bulimia is thought to be larger in quantity and calories than that consumed by individuals with BED (Rosen, Leitenberg, Fisher, & Khazam, 1986). At higher levels of obesity, however, the frequency of binge episodes and number of calories consumed during a binge for bulimic and BED individuals is similar (Fitzgibbon et al., 2000).

PREVALENCE

According to epidemiological studies using community samples, the rate of BED in the general population is between two and ten percent (Stickney & Miltenberger, 1999; Peterson & Mitchell, 1996; Bruce & Agras, 1992; Spitzer, Devlin, Walsh, Hasin et al., 1992). In a recent community-based survey in Australia involving 1,785 women and 2,725 men, the prevalence was estimated to be 2.5% (Hay, 1998). In a study of minority (which were mainly African American) and Caucasian groups, BED appeared to occur at comparable rates (Yanovski, Nelson, Dubbert, & Spitzer, 1993).

However, within the population attending weight control programmes, the rate of BED is between 30 and 55% (Spitzer et al., 1992; 1993; Telch, Agras, Rossiter, Wilfley et al., 1990; Gormally, Black, Daston, & Rardin, 1982). In a study involving 112 overweight patients seeking behavioral treatment for obesity, 55 % were found to have moderate problems with binge eating, while 23% were reported as having severe problems with binge eating (Gormally et al., 1982). In a similar study involving 71 men and 99 women who were participants in a weight control programme, 38.3% were found to fit the criteria for binge eating disorder (Wilson, Nonas, & Rosenblum, 1993). Within those attending Overeaters Anonymous specifically, the rate of those with BED is more than 70% (Spitzer et al., 1992; 1993).

AGE OF ONSET

In a study on a community sample by Spurrell and associates (1997), the mean age of onset was 12 years for those who binged prior to dieting. The mean age at which this group met the criteria for binge eating disorder was 19 years. For those that dieted prior to binge eating, the mean age of onset was 25 years. This group met the criteria for binge eating disorder at 33 years on average. It should be noted that these reports were done retrospectively, and may have been subject to memory biases, however, these results reflected those of previous studies (e.g., Mussell et al., 1995; Spitzer et al., 1993; Wilson et al., 1993). Thus, on average, the age of onset of binge eating problems and disorder is the late adolescence to early twenties.

NATURAL COURSE OF BED

A recent study on a community sample of 31 women attempted to document the natural course of binge eating disorder without treatment intervention for a period of six months (Cachelin, Striegel-Moore, Elder, Pike, Wilfley, & Fairburn, 1999). Of the 21 participants who completed the study, 11 still met the full criteria for binge eating disorder.

Nevertheless, 10 women appeared to be in a partial remission as their binge eating frequency had dropped to less than once per week over the follow-up period. Although for many women, binge eating disorder is a chronic problem that does not improve over time without treatment intervention, from this study it seems that binge eating frequency does improve for some individuals over time (Cachelin et al., 1999). However, relapse in eating disorders is common (Deter & Herzog, 1994; Keller, Herzog, Lavori, Bradburn et al., 1992; Mitchell, Davis, & Goff, 1985), and a recurrence of symptoms may have occurred over a longer follow-up period (Cachelin et al., 1999). Moreover, this study documents only the natural course of symptoms of women with binge eating disorder, many of whom declined further involvement in the study. Of the 48 women who were initially contacted, 35% refused to participate, and an additional 32% subsequently dropped out of the study. It was found that those that dropped out of the study were more likely to report a history of childhood sexual abuse, but due to the small sample size, this finding should be viewed as preliminary (Cachelin et al., 1999). Thus, future studies on the natural course of binge eating disorder should include a larger sample size, with a longer follow-up period to determine whether a relapse does occur over time in those that appear to have spontaneously recovered. In addition, future research should include male participants, particularly as many individuals with binge eating disorder are male (e.g., APA, 1994). Furthermore, prospective studies on the natural course of BED should attempt to determine why some individuals appear to spontaneously recover, while others do not. Such studies may allow insight into particular areas that need to be addressed in the treatment of chronic BED.

DIFFERENCES BETWEEN POPULATIONS

Males and Females with Binge Eating Disorder

While 90 percent or more of patients with anorexia nervosa and bulimia nervosa are women (e.g., APA, 1994), 30 to 40 percent of all binge eaters are men (APA, 1994; Becker, Grinspoon, Klibanski, & Herzog, 1999; Hay, 1998; Wilson et al., 1993). In the literature, there is a lack of information on males with binge eating disorder as most

research uses female participants (Tanofsky, Wilfley, Spurrell, Welch, & Brownell, 1997). However, in a study by Tanofsky and associates (1997), while no differences between men and women were found on self-esteem, eating disordered behaviour and eating related psychopathology, men were found to have greater comorbid Axis I psychopathology and higher distress than women. It was also found that men were more likely to have substance-related disorders, which was expected given that substance problems are more commonly diagnosed in men than women (Tanofsky et al., 1997). Tanofsky and associates (1997) speculated that higher levels of psychopathology may be due to the fact that men require a greater level of distress before seeking treatment for binge eating problems. The study also documented that women were more likely than men to admit to emotional eating. However, they suggested that this could be because men are either less likely to connect their eating to their emotions, or if they make the connection, are less likely to report emotional eating. Tanofsky and associates (1997) noted that this may be due to socialisation, where males are frequently socialised to suppress urges to verbalise their emotions, and instead are taught to express them through physiological or behavioral methods. This study was performed using clinical samples only, and further research is needed on community samples to compare men and women with nonclinical binge eating disorder.

Bulimia Nervosa Non-purging Type and Binge Eating Disorder Compared

Bulimia non-purging type (BN) and binge eating disorder share many similar characteristics, and are often treated in the same way (Agras, 1999; Romano & Quinn, 1995; Smith, Marcus, & Kaye, 1992; McCann & Agras, 1990; Telch et al., 1990). However, many recent studies have shown that they are two distinct disorders displaying specific symptomatology.

The majority of individuals who suffer from binge eating disorder are obese, while those suffering from BN are not (Romano et al., 1995; Spitzer et al., 1992; 1993). In fact, there is a robust association between BED and obesity (Spitzer et al., 1993; Marcus, 1996; Mussell, Mitchell, Weller, Raymond, Crow, & Crosby, 1995). Furthermore, it has often been noted that the severity of obesity increases steadily over time if the binge eating

problems are left untreated (Agras, Telch, Arnow, Eldredge, Wilfley, Raeburn, Henderson, & Marnell, 1994; Smith, Marcus & Kaye, 1992). For those with BED, binge eating occurs in the absence of compensatory behaviours. For those with BN, binge eating occurs in association with compensatory behaviours such as fasting, overexercising and laxative abuse (Santonastaso, Ferrara, & Favaro, 1999; Joiner, Vohs, & Heatherton, 2000; Castonguay, Eldredge, & Agras, 1995). In addition, although many researchers argue that BED may be a consequence of restrained eating (see Theories on Binge Eating and Etiology below), it has been argued that patients suffering from binge eating disorder are less restrained in their eating than those suffering from bulimia non-purging type (Marcus, 1996; Agras, 1995).

Psychological symptomatology also differs between the two eating disorders. Those with BED suffer from body image dissatisfaction, which is likely to be associated with higher body weight (Santonastaso et al., 1999; Marcus, 1996). However, unlike BED patients who suffer from body image disparagement, BN patients suffer from body image distortion (Romano et al., 1995). Thus, while those with BED view themselves accurately, those with BN tend to perceive their normal-weight body to be larger than it is in reality (Williamson, Muller, Reas, & Thaw, 1999; Marcus, 1996). Further, while binge eaters appear to have over-valued ideas about shape and weight as compared to non-eating disordered individuals (Becker et al., 1999; Romano et al., 1995; but see Marcus, 1996), they show less concern over shape and weight than those with BN (Marcus, Smith, Santelli, & Kaye, 1992).

Lastly, the majority of individuals suffering from BN are young females. However, individuals suffering from BED vary in age, and 40% are males (Becker, Grinspoon, Klibanski & Herzog, 1999; APA; 1994).

In summary, binge eating disorder and bulimia non-purging type appear to be two distinct eating disorders displaying different physiological and psychological symptomatology and related characteristics. Those with BN have more severe pathology than those with BED, and those with BED are often obese while those with BN are not.

Compulsive Overeating and BED Compared

Similarly to BED patients, compulsive overeaters have little meal structure and frequently report they do not eat in response to hunger cues (Romano et al; 1995; Johnson et al., 1995), however, evidence suggests that individuals with BED display higher psychopathy relative to compulsive overeaters (Spitzer et al., 1993). Moreover, compulsive overeaters lack the subjective distress that is clearly evident in BED (Romano et al., 1995). From the fact that compulsive over eaters and those with BED display different symptoms, it is evident that they are two different eating disorders, and thus researchers and therapists should treat them as such.

Night Eating Syndrome and BED Compared

Night eating syndrome (NES) was first documented by Stunkard and associates in 1955 (Stunkard, Grace, & Wolff, 1955). However, little is known about NES, and it is not known whether this is a type of disordered eating, or is just a habit (Stunkard, Berkowitz, Wadden, Tanrikut, Reiss, & Young, 1996). There are two criteria for NES, which are morning anorexia (lack of appetite in the morning) and evening hyperphagia (overeating in the evening), which refers to consuming greater than 50% of their daily calories after 7pm (Stunkard et al., 1955; 1996). Although BES and NES appear overlap in obese patients, and in fact some individuals require a dual diagnosis (Stunkard et al., 1996), they may be different behaviours (Adami, Meneghelli, & Scopinaro, 1999). Both NES and BES share many symptoms such as eating in response to negative affect, eating alone and until uncomfortably full, and feeling guilty or depressed as a consequence of an overeating episode (Napolitano, Head, Babyak, & Blumenthal, 2001). Adami and associates (1996) argue that those with NES lack symptoms that are correlated with binge eating, such as worry over food and diet and dissatisfaction with body. Moreover, those with BED do not typically have morning anorexia, or sleep difficulties, both of which are symptoms of NES (Stunkard et al., 1955; 1996). However, research on NES is only in its infancy. More studies are needed on non-clinical populations and non-obese populations to determine whether NES an eating disorder or a habitual behavior, and whether NES and BES are distinct or manifestations of the same disorder.

THEORIES

Individuals who engage in binge eating behaviours claim that the experience is unpleasant, particularly as binge episodes frequently result in negative emotional and somatic consequences (Lingswiler, Crowther, & Stephens, 1989) and yet they continue to do it (McManus, & Waller, 1995; Heatherton & Baumeister, 1991). There are many theories as to why this disordered, self-defeating behaviour occurs, and why it is maintained.

Risk Factors

Skipping lunch, snacking in the afternoon, eating supper, eating away from home, and snacking in the evening have all been cited as important risk factors for a binge episode (Johnson, Schlundt, Barclay, Carr-Nangle, & Engler, 1995). In addition, positive social situations are also risk factors for binge episodes to binge eaters, non-clinical binge eaters, and normal individuals (Johnson et al., 1995). This situation is characterised by a neutral or positive mood, and is precipitated by a meal eaten in a restaurant or in an out-of-the-ordinary place. This type of risk situation for a binge is often a planned social event (Johnson et al., 1995). However, these are risk factors for specific binge episodes, and they do not explain the maintenance of binge eating disorder generally.

Fairburn, Doll, Welch, Hay, Davies, and O'Connor (1998), found that there are many varying risk factors for the development of binge eating disorder. In a community-based study comparing 52 women with binge eating disorder, 102 with bulimia nervosa, 102 with other psychiatric disorders, and 104 without an eating disorder, they found negative self-evaluation, any history of parental depression, adverse childhood experiences including sexual and physical abuse and a range of parental problems, being repeatedly subjected to negative comments from the family about shape, weight, or eating, and pregnancy, before the onset of bingeing. However, other studies on sexual abuse do not support the hypothesis that sexual abuse is a risk factor for eating disorders generally (Pope & Hudson, 1992), due to the fact that prevalence rates of sexual abuse history in those that seek treatment for eating disorders are equivalent to those of the general

population (Pope et al., 1992).

Biological Theories

Set Point Theory

Set point theory was first developed by Nisbett (1972), and argues that the body has a natural weight that it endeavours to obtain and maintain (Heatherton & Baumeister, 1991). Thus, dieting is a key factor in attempting to maintain set point weight (Ruderman, 1986). Set point theory posits that in addition to slowing down its metabolic rate, binge eating may be another way the body naturally responds to numerous attempts and successes at weight loss (see Keeseey, 1986, for a review of the literature on Set Point Theory). This theory is supported by the fact that many dieters find initial weight loss comparatively easy, while subsequent attempts become increasingly more difficult (Sarafino, 1998). However, one of the major issues with this theory is that an individual's set point must be inferred as it can not be directly measured (Lowe, 1987). Moreover, this theory is yet to be tested on binge eaters, who, extrapolating from arguments regarding obese bulimics (see Heatherton et al., 1991) would be expected to have a higher set point as they are often obese.

Binge Eating as a Self-Medicating Behaviour

This theory argues that overconsumption of specific foods is a result of insufficient neurochemicals, namely serotonin (Wurtman, 1989). Thus, food rich in carbohydrates is used to regulate emotion by "self-medicating" in place of using drugs for the same purpose (Heatherton et al., 1991; Hudson, Pope, Wurtman, Yurgelun-Todd, Mark, & Rosenthal, 1988). This theory requires that individuals with disordered eating have abnormal levels of serotonin, which should be attributable to innate physiological differences. However, subsequent research has not been able to determine whether irregular levels of serotonin are attributable to genetic mechanisms or a natural side effect of dieting (Kaplan & Woodside, 1987). Moreover, those with BED consume food during binge episodes that resembles food consumed during a normal meal (Fitzgibbon et al.,

2000), and do not seem to prefer foods rich in carbohydrates (Goldfein, Walsh, LaChausse, Kissileff, & Devlin, 1993). Thus, the theory of carbohydrate craving for self-medication does not adequately explain the etiology of binge eating in those with BED.

The Appetite Control System

This theory argues that the appetite is controlled by behavioural, physiological, and neurochemical components, and a synchrony exists that adjusts eating behaviour with the aims of regulating biological mechanisms and environmental adaptation (Castonguay et al., 1995; Blundell & Hill, 1993). The appetite is controlled by a drive for energy, conscious recognition of hunger cues, taste preferences, selecting foods for their particular nutrients, cravings for particular foods, and a habitual pattern of eating behaviour (Blundell et al., 1993).

Binge eating results from a mild or severe disruption of either intrinsic or extrinsic factors, which in turn desynchronises the appetite control system (Castonguay et al., 1995). The term intrinsic factors refers to anything that happens under the skin (Blundell et al., 1993) and can include any type of flaw in their physiology or neurochemistry (Castonguay et al., 1995). Extrinsic factors are environmental events, or anything that happens beyond the skin (Blundell et al., 1993), and include the abundance of highly palatable, high-energy foods, severe dieting, prolonged fasting, or conditioning processes (Castonguay et al., 1995; Blundell et al., 1993). The chaotic eating patterns evident in those with BED may be associated with the desynchrony of the components of the appetite control system (Castonguay et al., 1995).

However, research evaluating the effects of appetite suppression on improving binge eating frequency is scarce. Studies that do address the issue of pharmacotherapy on BED generally focus on the use of antidepressant medications. One study compared the effects of cognitive behavioural therapy, weight loss treatment, and the effectiveness of using desipramine on improving binge eating symptoms by suppressing urges to binge (Agras, Telch, Arnow, Eldredge, Wilfley, Raeburn, Henderson & Marnell, 1994). Desipramine, which is thought to suppress appetite and overeating by reducing hunger cues (McCann

et al., 1990) but is also a tricyclic antidepressant (Marcus, 1996), was introduced to a group that had initially received cognitive behavioural therapy for the first three months of treatment. The participants received weight loss therapy combined with desipramine for three months following the cognitive behavioural therapy (Agras et al., 1994). It was found that the appetite suppressant did not reduce the frequency of binge eating after three months of use, although those receiving the medication did lose more weight than the group that did not receive it at follow up (Agras et al., 1994). Agras and associates (1994) suggested that desipramine may have facilitated weight loss through emotional regulation properties rather than suppressing appetite. Another study that tested the efficacy of employing appetite suppressants to treat BED found that while the medication did reduce binge eating frequency so that eight out of the ten participants that had adequate plasma levels of the drug ceased binge eating, there was also a strong placebo response (Stunkard, Berkowitz, Tanrikut, Reiss, & Young, 1997). In contrast, in a 12 week, double-blind study on the tricyclic anti-depressant desipramine, McCann and Agras (1990) found a mean reduction in binge eating of 63% for those using the drug compared to the 16% increase in binge eating for those in the placebo condition. In addition, removal of the drug after the 12 week study produced a rapid relapse (McCann et al., 1990). However, a study by Agras and associates did not find any improvement to binge eating symptoms when they added desipramine during the last six months of a nine month phase of employing CBT to treat binge eating and weight loss (Agras, Telch, Arnow, Eldredge, Wilfley, Raeburn, Henderson, & Marnell, 1994). In summary, although studies are mixed, research to date does not appear to support the appetite control system in explaining the etiology and maintenance of binge eating problems.

Psychological Theories

Personality Types

Both the personality traits exhibiting impulsive behaviours and dissociation have been associated with BED. Individuals with BED are noted to “cut-off” or dissociate from painful emotions and respond in impulsive ways such as binge eating (Carlson & Putnam,

1993). Lacey and Evans (1986) have argued that it is the culmination of the dissociative and impulsive tendencies, added to aversive negative affect and lack of effective coping strategies, that leads to binge eating problems. They argue that binge eating behaviour is exacerbated by traumatic or stressful events, which are associated with negative affect. Binge eating problems are said to be self-maintaining, as impulsive behaviours such as drug taking or lack of sexual inhibition, expose the individual to an increased risk of experiencing further traumatic or stressful events. These events produce negative emotional responses, which lead to an increased need to dissociate from painful emotional states. This increased need to dissociate from negative emotions leads to further impulsive behaviours, and so on (McManus et al., 1995).

Restraint Theory

The construct of restraint was first developed by Herman and Mack (1975) and was intended to further argue Nisbett's set point theory (1972). Although there were many problems in evaluating set point theory (see above), the role of dieting in influencing eating patterns drew the interest of many subsequent researchers (Ruderman, 1986). As has been noted, those with binge eating disorder are frequently overweight or obese (Romano et al., 1995; Spitzer et al., 1992; 1993). It has been well documented that the self-perception of being overweight or obese is highly aversive (Dejong & Klack, 1986), and this is perpetuated by societal messages indicating that it is undesirable to be overweight (Marcus, 1996; Heatherton et al., 1991; Nisbett, 1972). Many individuals with binge eating disorder are or have been on a diet, and investigators have argued that dieting is a key risk factor for BED (Heatherton & Baumeister, 1991; Streigel-Moore, 1993). In addition, it has been suggested that low self-esteem results in overconcern about shape and weight, which leads the individual to extreme dieting (Fairburn & Cooper, 1989).

Restraint theory argues that individuals with eating disorders actively restrain their eating in two ways. First, the person may restrain or reduce their eating to specific caloric levels or dietary boundaries for weight loss, or maintenance of a desired weight (Laessle, Tuschl, Kotthaus, & Pirke, 1989; Herman & Polivy, 1984). Second, they may avoid

particular foods they have labeled as “bad” (Knight & Boland, 1989; Polivy & Herman, 1985). Some may restrain by doing both.

Restraint theory for binge eating argues that disinhibited eating is central to binge episodes. Dieting or restraint efforts become disinhibited through the person perceiving they have over eaten (Ruderman, 1986). It is assumed that those who are dieting or restrain their eating do so in an “all-or-nothing” manner (Ruderman, 1986), and judge that slipping up once is equivalent to abandoning their diets entirely (Herman & Mack, 1975). Once they perceive they have broken their dietary rules, they respond with thoughts such as “I’ve blown it – I might as well continue to eat.” (Ruderman, 1986; Herman et al., 1975). Thus, the perception of having over eaten disinhibits restraints they have placed on their eating. In addition, disinhibition of restraint also occurs when the individual intentionally uses alcohol or drugs, when they are dysphoric in mood, when another person or other individuals are present, and when the person discontinues to monitoring their restraint efforts (for a review, see Ruderman, 1986). Thus, violating individual dietary rules, intentional use of alcohol or drugs, dysphoric mood, social influences, and discontinuation of self-monitoring efforts appear to perpetuate or prolong disinhibited eating, and efforts at restraining eating are temporarily abandoned (Johnson, Schlundt, Barclay, Carr-Nangle, & Engler, 1995; Ruderman, 1986; Herman & Polivy, 1980; Spencer & Fremouw, 1979).

Although some studies provide evidence for the restraint theory of binge eating (e.g., Rossiter, Agras, Telch, & Bruce, 1992; Eldredge & Agras, 1994), just as many studies exist that report evidence contrary to this theory (e.g., Brody, Walsh & Devlin, 1994; Marcus, Smith, Santelli, & Kaye, 1992; Marcus, Wing & Hopkins, 1988). In the literature, the terms dieting and restraint are often used interchangeably (Stice, Akutagawa, & Agras, 2000). However, it has been argued that while dieting refers to intentional efforts to achieve or maintain a specific desired weight (Laessle et al., 1989), restraint refers to individuals who attempt to diet, but instead overeat intermittently (Heatherton, Herman, Polivy, King, & McGree, 1988). Alternatively, Lowe and associates have argued that restrained eating refers to preventing weight gain, while

dieting refers to actively attempting to lose weight (Lowe, Whitlow, & Bellwoar, 1991). This may account for some of the discrepancies in the findings on restraint theory of binge eating.

One of the main arguments against the restraint theory of binge eating is the temporal placement of the acts of dieting and binge eating. Given that bulimia nervosa and BED display similar characteristics, it was originally thought that, like bulimia nervosa, dieting would play a significant role in binge eating disorder. However, subsequent studies have shown that unlike bulimia nervosa patients, the majority of those with BED reported that binge eating occurred before their first diet (Spurrell, Wilfley, Tanofsky, & Brownell, 1997; Marcus, 1996; Mussell, Mitchell, Weller, Raymond et al., 1995; Spitzer et al., 1993). Thus, it appears that for many bulimia nervosa patients, binge eating is a consequence of dieting, while for many BED patients, binge eating is the cause of dieting (Marcus, Wing, & Fairburn, 1995). This indicates that binge eating develops in the absence of significant dieting or weight problems (Mussell et al., 1995), which provides evidence against the restraint theory of binge eating for BED.

In addition, in the successful treatment of BED, restraint levels can remain unchanged (Smith, Marcus, & Kaye, 1992), or increase posttreatment (Yanovski & Sebring, 1994). Further, not all binges are in response to food cravings, as even those who have been nutritionally deprived do not binge in response to cravings (McManus et al., 1995). It has been suggested that it may not be restraint that plays a significant role in BED. Instead, chaotic eating patterns may promote binge eating problems (Castonguay et al., 1995).

Externality Theory

This theory claims that overeating, and therefore binge eating, is a function of food-relevant cues, such as sight, taste and smell (Schachter, 1968; Andrews & Jones, 1990) and proximity and quantity of food (Nisbett, 1968). Schachter (1971) proposed that in Western societies, although food cues are constantly available to their senses, obese individuals still eat less often than normal-weight people, however, when they do eat, they tend to eat more in volume (Schachter, 1971). Thus, it may be the potency of the

available food cues that is an important factor in overeating in the obese (Schachter, 1971). A study by Andrews and Jones (1990) tested whether overeating was a result of salient food cues, or an interaction between external cues and emotional state. When the food was in view and was deemed relatively attractive, overeating was much more likely to occur. Moreover, an interaction between food saliency and the intensity of the emotional state were found to predict a bout of non-nutritional overeating (Andrews et al., 1990). However, the study relied solely on self-report, and although this was done at the time of the behaviour to reduce memory bias, no procedures were used to validate the recordings of the participants. Further, all the participants were selected from various Weight Watchers groups. Nevertheless, this study raised an important issue, that it may not be one single cause of binge eating episodes, but a multitude of interacting factors.

PSYCHOLOGICAL THEORIES THAT INCLUDE THE ROLE OF EMOTIONS IN BINGE EATING

Negative emotions are often cited as potent precipitants to binge episodes (e.g., Abraham et al., 1982; Lingswiler et al., 1989; Arnow et al., 1992;1995; Polivy & Herman, 1993), and they are considered a serious risk to binge eating and BED.

Psychosomatic Theory

This theory is considered the rival theory to externality theory of binge eating (Heatherton et al., 1991). It proposes that overeating is not a response to intense salient cues of food, but instead a way of avoiding or reducing the anxiety produced by stressors (Slade, 1982; Bruch, 1961). It has been argued that because cessation of eating would reestablish the stress, eating to avoid distress is maintained (Heatherton et al., 1991). Thus, the psychosomatic theory argues that those with BED binge in response to anxiety, either as a response to a stressor, or to avoid the stress reaction caused by the stressor.

Escape model

An alternative argument is the escape model which states that binge eating may be an escape from one's self awareness (Castonguay, Eldredge, & Agras, 1995; Heatherton & Baumeister, 1991). This theory is based on the assumption that binge eaters suffer from an aversively high level of self awareness, which stems from the characteristically high standards and expectations they place on themselves (Heatherton et al., 1991). It begins with a comparison of the self against these high ideals, and a striving for perfection (Heatherton et al., 1991). When these expectations are not met, self-awareness increases to an intolerable level which is perpetuated by an unflattering view of themselves and concern over how others perceive them (Heatherton et al., 1991). Their attention becomes focused on personal inadequacies, faults, or other deficiencies, which may be reflected in low self-esteem and is sustained by their irrational beliefs (Heatherton et al., 1991). This state of self-awareness produces emotional distress characterised by depression and anxiety, and to escape this state, binge eaters respond by eating. Eating in turn produces a type of perceptual narrowing, which focuses their attention on the food. Concentrating on the immediate stimulus, the food, allows them to avoid meaningful thought (Heatherton et al., 1991) and temporarily distracts them from negative emotions (Lingswiler, Crowther, & Stephens, 1989).

Although the evidence is not conclusive, some studies of the cognitive states of bulimics and dieters have shown indications of dichotomous thinking, which is represented by rigid thinking and rejection of meaning (Fairburn & Cooper, 1987; Polivy & Herman, 1985; 1987; Williamson, 1990). In addition, cognitive rigidity is also evident in the tendency of many dieters and bulimics to label foods as either "good" or "bad" (Knight et al., 1989; Polivy et al., 1985). Such studies remain to be performed, however, on participants with binge eating disorder. Thus, whether binge eating results in a cognitive narrowing for those with BED is yet unknown.

Heatherton and Baumeister (1991) also argue that individuals with eating disorders respond to stress by avoidance coping. Many theorists have argued that those with binge

eating problems use avoidance coping to deal with stress (Paxton & Diggins, 1997; Wilfley et al., 1997; Castonguay et al., 1995; Yanovski, Nelson, Dubbert, Spitzer, 1993), rather than more adaptive coping techniques. Heatherton and Baumeister (1991) state that avoidance is similar to escape, and that this type of coping style provides support for the escape theory of binge eating.

In summary, escape theory maintains that binge eating is an attempt to reduce the negative emotional distress which accompanies aversive self-awareness. Heatherton and Baumeister (1991) emphasise the role of internal events in the aversive self awareness and the etiology of BED. They also argue that bingeing results from cognitive mechanisms designed to reduce self awareness (Heatherton et al., 1991). Further, they argue that it supports both the psychosomatic and externality theories, as it simultaneously predicts externality and anxiety reduction (Heatherton et al., 1991). The shift in focus of attention and the reliance on the salient external cues of the food results in a reduction in anxiety (Heatherton et al., 1991). Heatherton and Baumeister (1991) state that the escape model of binge eating is a general and comprehensive theory that combines rather than rivals the arguments of many theorists.

Interpersonal Problems

The interpersonal model of BED argues that interpersonal problems have a negative influence on self-esteem, causing low self-esteem, which in turn triggers binge eating (Agras, 1991). Interpersonal problems that trigger binge eating episodes revolve around interpersonal deficits, disputes, role transitions, and unresolved grief (Castonguay et al., 1995; Lacey, 1986b). The interpersonal model emphasises the role of external events in the etiology of BED (McManus et al., 1995).

As interpersonal therapy (IPT) has had some success in treating binge eating problems in those with BED without actually targeting eating behaviour, it can be concluded that factors that negatively impact on interpersonal functioning are critical in the maintenance of binge eating problems for some people (Castonguay et al., 1995). However, the interpersonal model of BED fails to suggest the exact mechanisms that link interpersonal

problems, low self-esteem, negative affect, and the etiology and maintenance of binge eating problems (Castonguay et al., 1995).

Learned Behaviour

It has also been argued that overeating may be a learned behaviour, which occurs when a parent mistakes a child's cries of emotional distress for cries of hunger (Andrews & Jones, 1990). This association between emotional distress and eating may be partially conditioned, so that the individual deliberately and habitually turns to food when they are emotionally distressed, or when they are emotionally distressed falsely believe that they are hungry (Andrews et al., 1990).

The eating response is maintained through a learned response to stress, which is argued to produce a "false" hunger (Robbins & Fray, 1980). When a stressor is encountered, the stress response is mistaken for hunger, and consequently eating occurs in response to false hunger cues. Further, the act of eating in response to negative emotions may be reinforcing, thus perpetuating future episodes. Eating is said to reduce the intensity of the hunger, which is actually emotional distress (Robbins et al., 1980). Thus the behavioural pattern of eating in response to emotional distress is reinforced by the reduction of emotional distress when food is consumed (Robbins et al., 1980).

Binge Eating as an Affective Disorder

Many theorists have argued that because binge eating and bulimia nervosa are often comorbid with depression and anxiety disorders, and that BED is in fact an affective disorder (Castonguay et al., 1995). However, this has been rejected, based on studies on antidepressants for medication for both bulimics and individuals with BED. Among many reasons, the fact that relapses occur while individuals are still on medication and that medications with varying pharmacological effects produce similar results provide strong evidence against the theory that BED is an affective disorder (see Fairburn, Agras, & Wilson, 1992 for a review of the argument for BN). Nevertheless, depression does appear to contribute to BED and obesity, and may exacerbate binge eating problems (Smith et al., 1994). Further, the prevalence of anxiety disorders among those with BED has shown

to be high compared to the general population (Marcus, Wing, Ewing, Kern, Gooding, & McDermott, 1990; Yanovski, Nelson, Dubbert, & Spitzer, 1993). Thus, while BED is not an affective disorder, it is highly comorbid with anxiety disorders and depression. The relation between eating disorders and mood disorders is consistent with modified psychosomatic and escape theories.

Affect Regulation Model

The affect regulation model asserts that those with binge eating problems do so to deal with negative emotions such as anxiety, depression and anger (Stice, Akutagawa, Gaggan, & Agras, 2000; Schmidt, 1998; Johnson et al., 1995; Agras, 1995), particularly as they may have a lower tolerance of emotional distress (Kenardy, Arnow, & Agras, 1996). Binge eating may help alleviate the distress (Heatherton & Baumeister, 1991), and provide comfort as it distracts them from their emotions (Stice, Agras, Telch, Halmi, Mitchell, & Wilson, 2001; Lacey, 1986). The affect regulation paradigm also argues binge eating may be used to replace emotional states that are deficient, such as loneliness and boredom (Meyer & Waller, 1999; McManus & Waller, 1995). Thus, it argues that negative affect precedes binge eating behaviour (Arnow, Kenardy, & Agras, 1992), and binge eating is considered a maladaptive emotion regulation coping response (Wiser & Telch, 1999). "Women who binge have learned that binge eating can be a quick fix that numbs painful emotions." (Arnow, Kenardy, & Agras, 1992). In addition, it has also been documented that the emotions typically reported prior to a binge, such as anger, are less easily tolerated than those that follow a binge episode, such as guilt (Kenardy et al., 1996).

While the escape theory and the affect regulation model both argue that binge eating is a response to negative emotions and help to alleviate or regulate acute negative affect (Heatherton et al., 1991), Heatherton and Baumeister argue that emotional distress is most likely to be accompanied by low self-esteem and aversive self-awareness. The affect regulation model asserts that the negative emotions that precede binge eating are not necessarily caused by self-awareness and low self-esteem. Moreover, the affect regulation paradigm states that binge eating produces a reduction in emotional distress

and may provide an escape from the negative affect (Stice et al., 2001), while the escape theory argues that reduced affect and binge eating occur simultaneously resulting from escape from self-awareness (Heatherton et al., 1991).

Research evaluating the role of emotions in binge eating has tended to support the affect regulation model (e.g., Kenardy et al., 1996; Johnson et al., 1995; Cools, Schotte, & McNally, 1992; Schotte, Cools, & McNally, 1990). Johnson and associates (1995) compared 25 individuals with binge eating disorder, 19 individuals classified as non-clinical binge eaters, and 26 normal individuals selected from a community sample. They documented that although all individuals binged when feeling extremely negative emotionally, those with BED and the non-clinical binge eaters (NCB) did so in response to moderately negative emotions (Johnson et al., 1995). This led them to conclude that those who were classified as clinical and non-clinical binge eaters binged to cope with their problems and ate to assuage less severe negative emotions than normal individuals (Johnson et al., 1995). They argued that binge eaters may not begin eating with the intention of bingeing, but having started, they lose the ability to exercise control over the food they are consuming during the eating episode (Johnson et al., 1995). This has also been argued by other researchers (e.g., Sanftner & Crowther, 1998). However, the authors relied on the QEWP as their sole assessment tool for classifying those with BED and NCB. Moreover, they could not establish from their study whether those classified as NCB were static or whether they were representative of a transitional phase which would eventually become binge eating disorder (Johnson et al., 1995). Nevertheless, the finding in this research that those with BED binged to regulate negative affect supports that of other studies (e.g., Kenardy et al., 1996; Eldredge & Agras, 1996; Cools, Schotte, & McNally, 1992; Schotte, Cools, & McNally, 1990).

Although there is a notable absence of comparisons between men and women with binge eating disorder, one study by Tanofsky and associates did compare them across several dimensions (Tanofsky, Wilfley, Spurrell, Welch, & Brownell, 1997). They found that men and women did not differ on measures of eating disturbance, shape and weight concerns, interpersonal problems, and self esteem (Tanofsky et al., 1997). However, they

found that men and women did differ in that women were more likely to report eating in response to negative emotions specifically anxiety, depression and anger (Tanofsky et al., 1997). Nevertheless, they were not able to establish whether men did not eat in response to negative emotions, or whether they were less likely to report doing so. They noted that it was likely that men were just as likely as women to eat in response to negative emotions, but were less likely to report it due to social pressures (Tanofsky et al., 1997). In support of this hypothesis is a study by Brody and Hall (1993) on gender and emotions in children. They found that while girls were taught to express their feelings through verbal and facial expression, boys were taught to suppress the verbal expression of their feelings, but to instead express them through physiological or behavioural methods (Brody & Hall, 1993). This study employed participants from clinical samples. Thus, future research would not only need to address whether men eat in response to negative emotions to the same degree as women, but also need to employ participants from community samples (Tanofsky et al., 1997).

Notably, one study by Telch and Agras (1995), failed to provide support for the affect regulation model. They studied a total of 60 women, 30 who were diagnosed with BED through a structured interview and using the Questionnaire on Eating and Weight Patterns (Spitzer et al., 1993), and the other 30 were overweight non-eating disordered women. The participants were told not to eat after midnight the previous night, and were given a standard breakfast at 8am and lunch at 12 noon. They were then randomly allocated to a neutral or negative mood induction condition. Those in the negative mood induction condition were given instructions that were played on a tape recorder that told them to remember as vividly as possible a past event that caused them to feel extreme negative emotions, and to feel the same negative feelings and think the same thoughts as they did when it happened. Those in the neutral condition were given similar instructions except they were instructed to bring to mind a neutral past event or situation, such as running an errand or doing a routine daily activity. All participants were then presented with an extensive buffet that included foods such as M&Ms, pizza and glazed donuts, and were told "let yourself go and eat as much as you want" and to take as long as they needed (Telch et al., 1995).

The researchers found that there were no significant differences between the caloric intake of eating disordered and non-eating disordered individuals in the neutral and negative mood induced conditions. However, they did find that negative mood influenced the way in which the food consumed was labeled (Telch et al., 1995). Those with BED who labeled their eating a binge episode reported a more significant negative affect state than those who labeled their eating as overeating (Telch et al., 1995). Thus it was not the amount of food that was consumed that influenced how the participants with BED labeled their food, but it was their mood that affected their perceptions and subsequent labeling of the eating episode (Telch et al., 1995). Although this study provides interesting support for the importance of the subjective experience in the definition of a binge, it contains several methodological concerns. It is possible that despite the fact that those in the mood-induction condition reported a significantly greater level of negative mood than those in the neutral condition, the negative mood that was induced was not sufficient to influence the amount of food eaten by those with BED. Future studies may require visual as well as auditory cues to induce a negative mood sufficient enough to influence eating behaviour. In addition, those with BED prefer to eat alone at home during a binge (APA; 1994), rather than in a group such as a buffet. The fact that binge eating is performed in private poses a difficulty for those studying binge eating disorder as researchers have to rely on self report measures from the participant. Reports from peers and family members may have inaccuracies due to the private nature of binge eating in BED. Studies performed in a laboratory will always be biased by the fact that the participant is aware they are being watched.

Summary

Evidence of the association between binge eating and emotions comes from both clinical reports (e.g., Arnow et al., 1992) and experimental studies (e.g., Telch et al., 1996). However, no particular theory has been able to unequivocally account for the etiology and maintenance of BED.

CURRENT TREATMENTS

There are three main types of therapy that are employed to treat binge eating disorder. These are cognitive-behavioural treatments (CBT), interpersonal treatment (IPT), and biological treatments. A new type of therapy, dialectical behaviour therapy is currently being investigated, and is claimed to show promise in effectively reducing binge eating syndromes.

Cognitive-behavioural Treatment

The cognitive behavioural approach to treating binge eating problems is based on the restraint and avoidance theories of binge eating (Castonguay et al., 1995) and argues that cognition influences the etiology and maintenance of BED (Williamson, Muller, Reas, & Thaw, 1999). It is based on the assumption that, like bulimics, individuals with BED have overvalued ideals about shape and weight concerns as compared to obese nonbingers (Agras, 1999;1993; Williamson et al., 1998;1999; Castonguay et al., 1995).

Cognitive risk factors are distorted and dichotomous thinking regarding food and eating, body dissatisfaction, unrealistic standards and expectations of the self, and internalisation of the “thin ideal” (Wiser & Telch, 1999; Agras, 1999; Castonguay et al., 1995).

Behavioural risk factors stem from food restrictions and restraints (Wiser et al., 1999; Agras, 1999; Castonguay et al., 1995). The cognitive-behavioural theory argues that the structure of thinking is organised by schemata, and while schemata generally organises memory and cognitive processing in a positive way, these knowledge structures can bias thinking and behaviour in a self-destructive or maladaptive manner (Williamson et al., 1999). Those with an eating disorder are said to have developed maladaptive schemata regarding shape and weight (Williamson et al., 1999). Underlying these concerns are ingrained basic beliefs (see Freeman, 1995) and chronic feelings of ineffectiveness and worthlessness (Schmidt, 1998).

Cognitive-behavioural treatment is a structured, short-term therapy (Devlin, 1996). It is based on CBT for bulimia nervosa, which was first devised by Fairburn in 1981. It is

founded on the two principal components of the disorder proposed by researchers on bulimia, the behaviour component and the cognitive component. It emphasises breaking the cycle of dieting and bingeing by normalising eating patterns (e.g., Wilson & Fairburn, 1998; Marcus, 1996; Castonguay et al., 1995), and modifying both pathological behaviour and cognition relating to the body and eating (Williamson, Womble, & Zucker, 1998; Williamson et al., 1999). More recently, CBT has included dealing with the avoidance of painful self-awareness (Heatherton et al., 1991).

There are three stages to CBT for bulimia and binge eating disorder: (1) introduction and education, (2) cognitive restructuring, and (3) relapse prevention (Agras, 1999; Fairburn & Cooper, 1989). The first stage involves discussing the cognitive model, educating the patient about the etiology and maintenance of their eating problem, and reviewing the treatment goals (Williamson et al., 1998). The patient is given counselling in nutrition, training in self-monitoring of their food intake, and are given an overview of behavioural techniques they can use to normalise their eating patterns such as stimulus control techniques (Agras, 1999; Williamson et al., 1998; Castonguay et al., 1995). The second stage is modeled after Beck's (1976) cognitive therapy for depression. The relationship between feelings, thoughts, and behaviours is outlined, and the patient is taught to address irrational thoughts and beliefs concerning food, weight gain and body shape identified in their self-monitoring (Williamson et al., 1998;1999). Irrational beliefs are approached by offering the patient rational alternatives, and the patient is encouraged to offer their own substitutions (Williamson et al., 1998;1999). The patient is persuaded to act in a way that will disconfirm their beliefs (Williamson et al., 1998). In addition, the patient is given education and formal problem solving skills (Agras, 1999; Castonguay et al., 1995; Wilfley, Agras, Telch, Rossiter, Schneider, Cole, Sifford, & Raeburn, 1993). The third stage, relapse prevention, involves combining cognitive and behavioural techniques to ensure the treatment effects are maintained (Williamson et al., 1998), and the patient develops methods of coping with specific situations (Agras, 1999). The therapist emphasises that minor lapses are acceptable as long as the trend is towards healthier eating, and the patient is motivated by the therapist to identify risk factors from the experience (Williamson et al., 1998).

One of the first studies that investigated the effectiveness of CBT on treating BED showed an 80% abstinence rate from binge eating at the end of a ten week programme (Telch, Agras, Rossiter, Wilfley, & Kenardy, 1990). This result was replicated with the control group. However, at the 20 week assessment, those in the initial group had lapsed from post-treatment levels, although their binge eating remained improved compared to before the treatment (Telch et al., 1990). As a result of this study, it was speculated that extended therapy may yield more stable results. Subsequently, Eldredge and associates studied the effects of extending CBT for initial treatment nonresponders in 44 women and two men (Eldredge, Agras, Arnow, Telch, Bell, Castonguay, & Marnell, 1997). They showed that after 12 weeks, 18 of the 36 participants in the treatment condition no longer met the criteria for BED. After an additional 12 weeks of CBT that focused on specific problem areas identified by the participants at the end of the initial 12 weeks, 6 of the total 14 initial nonresponders no longer met the criteria for BED (Eldredge et al., 1997). They did note, however, that after 20 weeks treatment effects ceased to occur (Eldredge et al., 1997). Although the authors did not suggest a reason for this, it is likely that CBT is limited in dealing with the specific needs of the individual. Thus, while it is effective to a certain degree for some individuals, CBT fails to address many of the issues of BED. In a 6 year follow-up study on the effectiveness of CBT for treating BED, it was found that while a significant number of the participants had improved considerably directly after treatment from pre-treatment, the treatment effects were not well maintained (Fichter, Quadflieg, & Gnutzmann, 1998).

Additionally, researchers have also investigated the relative effectiveness of using self-help manuals in guided and unguided conditions. Self-help manuals adhering to a CBT framework appear to be helpful in treating BED when used by the individual alone, although they are not as effective as therapist-led guidance (Peterson, Mitchell, Engbloom, Nugent, Mussell, Crow, & Thuras, 2001; Loeb, Wilson, Gilbert, & Labouvie, 2000; Peterson, Mitchell, Engbloom, Nugent, Mussell, & Miller, 1998; Carter & Fairburn, 1998; Fairburn & Carter, 1996).

In summary, CBT has been found useful as a short-term treatment for some individuals with BED. However, it is not effective in treating all individuals with BED, and is not effective for treating BED in the long term.

Interpersonal Therapy

The interpersonal approach to treating binge eating disorder is similar to the escape theory, although no specific model has been devised from within this theory to explain how interpersonal problems relate to the etiology and maintenance of BED (Castonguay et al., 1995). The theory is based on the assumption that there is an interrelationship between negative mood, low self-esteem, interpersonal functioning, and eating behaviour (Fairburn, Jones, Peveler, Carr, Solomon, O'Connor, Burton, & Hope, 1991). In particular, it is based on the premise that interpersonal problems cause low self-esteem, which subsequently causes adverse negative emotions, which triggers binge eating (Agras, 1991;1993;1995; Arnow, Kenardy, & Agras, 1992). According to the interpersonal approach, binge eating becomes a means by which individuals with BED cope with the negative affect associated with interpersonal problems (Agras, 1993;1995). Interpersonal risk factors revolve around isolation, interpersonal difficulties, and dissatisfaction regarding interpersonal relations (Wiser et al., 1999; Lacey, 1986b). Thus, IPT aims to improve interpersonal disputes and deficits, such as social avoidance (Eldredge, Locke, & Horowitz, 1998), the effect of role transitions, and unresolved grief in those with BED (Wiser et al., 1999; Castonguay et al., 1995; Agras, 1993;1995).

One major study tested the effectiveness of IPT compared with that of CBT in treating bulimia nervosa non-purging type (Wilfley, Agras, Telch, Rossiter, Schneider, Cole, Sifford, & Raeburn, 1993). The study employed a total of 56 participants who were diagnosed as having bulimia non-purging type. All participants were randomly assigned to three groups, 18 participants to the CBT group, 18 to the IPT group, and 20 to a waiting list condition. Those in the waiting list group were assessed at the beginning and end of a 16 week period, but were not otherwise contacted. Those in the CBT and IPT groups attended a weekly, 90 minute group therapy session for 16 weeks. Both types of therapy were equally effective in reducing binge frequency (Wilfley et al., 1993).

The participants in this study were assessed as having bulimia nervosa non-purging type based on (a) recurrent episodes of binge eating in which the subject perceived herself to consume a large amount of food in a short period, (b) a feeling of lack of control or inability to stop eating during the eating binges, (c) an average of two or more binge episodes per week for the past 6 months, (d) persistent concern with body shape and weight. They were excluded if they were currently, or had in the past, self-induced vomiting, laxative use, or other purging behaviours (Wilfley et al., 1993). Therefore, the results could be generalised to the treatment of BED, and indeed they do reflect those of subsequent studies investigating the efficacy of using IPT to treat BED (Peterson & Mitchell, 1999; Birchall, 1999; Agras, Telch, Arnow, Eldredge, Detzer, Henderson, & Marnell, 1995).

A similar study compared IPT to CBT and behaviour therapy in treating those with BN. While CBT was superior to IPT and behaviour therapy at the end of treatment, at a 12 month follow-up, the differences disappeared (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993). Thus, it was concluded that CBT and IPT are equally effective in treating BN, though they appear to operate differently (Fairburn et al., 1993). Further study tested the effectiveness of using IPT to treat those with BED who did not respond to CBT (Agras et al., 1995). It was found that after a 12 week trial, IPT did not lead to further improvement. This is possibly because those who did not respond to either treatment had a more severe clinical status (Agras et al., 1995). Longer treatment, or individual treatment may have yielded more positive results (Marcus, 1996).

In summary, both CBT and IPT appear equally effective in treating BN, and yield similar results in treating those with BED. However, it is not clear whether specific individuals are likely to respond to different treatments, or whether the same individuals are likely to respond to either CBT or IPT (Eldredge et al., 1997).

Biological Therapy

There are two major biological approaches to treating BED, namely appetite suppressants and anti-depression medications. The use of appetite suppressants for the treatment of

BED was based on the theory that binge eating disorder is maintained by the appetite control system. However, studies evaluating the efficacy of using appetite suppressants are rare, and those that had been performed do not support the use of this medication to treat BED (see *The Appetite Control System* in the Theories on Binge Eating and Etiology section).

The use of anti-depression medication was based on the premise that binge eating is an affective disorder, but this has since been rejected as the medication did not improve binge eating syndromes when used alone or in conjunction with other therapies (see *Binge Eating as an Affective Disorder* in the Theories on Binge Eating and Etiology section). Nevertheless, anti-depressant medication may be of use in treating major depressive disorder that occurred before BED, or in treating depressive symptomatology that does not abate following treatment for the eating disorder (Mitchell & deZwann, 1993). Caution must be exercised when using pharmacotherapy to treat depressive symptoms related to binge eating due to the risk and adverse effects of the treatment (Devlin, Goldfein, Carino, & Wolk, 2000). For instance, the combination of phentermine and fluoxetine used to treat binge eating symptoms and obesity produced strong side effects of insomnia and anxiety in a recent study (Devlin et al., 2000).

THE FAILURE OF CURRENT TREATMENTS TO ADDRESS THE LINK BETWEEN BED AND EMOTIONS

It is clear that both CBT and IPT are effective, but somewhat limited, in treating BED. Neither treatment is capable of completely eliminating binge eating behaviours for the long term. This limitation may be explained by the lack of attention to emotional influences in binge eating.

“Although both CBT and IPT may ultimately impact emotional distress, neither treatment contains specific treatment components that target emotional regulation. The absence of a

specific focus on affect regulation may account for the limitations of these treatments in eradicating binge eating for some patients.” (Telch, 1997).

Dialectical Behaviour Therapy (DBT)

Dialectical Behaviour Therapy is based on the affect regulation model, and focuses on emotion regulation skills. It argues that binge eating behaviours originate from the threat or presence of an unpleasant emotional experience (Wiser et al., 1999). While cognitive-behavioural therapy argues that binge eating results from distorted ideals about shape and weight and from restrictive eating patterns, and interpersonal therapy emphasises the primary role of interpersonal difficulties in binge eating, the affect regulation model maintains that binge eating occurs as a result of the individual’s inability to deal effectively with negative emotions. Thus, regardless of the cause of the aversive negative affect, be it cognitive or interpersonal, the individual will engage in binge eating behaviours if they do not feel equipped to deal with the aversive affective state (Wiser et al., 1999). The behaviour is reinforced as engaging in a binge episode “works” by reducing the intensity of the negative affect, particularly as the aversive affect is intolerable (Wiser et al., 1999). The individual then learns to cope with negative affect and distress by binge eating, rather than using more adaptive coping styles (Wiser et al., 1999). Risk factors for a deficit in affective regulation include low self-esteem, anxiety, and dysphoria (Wiser et al., 1999).

The therapy is based on DBT for borderline personality disorder (Linehan, 1998), and has been empirically validated (Wiser et al., 1999). It is a long-term treatment that aims to improve behaviour that is life-threatening or impairs the quality of life of the individual (Wiser et al., 1999). It emphasises specific instruction, practice, and mastery of self-regulatory skills that the patient may have failed to develop earlier in life (Arnold, 1999).

The treatment normally consists of four main components: (1) mindfulness skills, (2) distress tolerance, (3) emotion regulation, and (4) interpersonal effectiveness (Wiser et al., 1999). However, so that DBT can be effectively compared with therapy that focuses on interpersonal skills, such as IPT, the fourth component has not been included in recent

research (see Wiser et al., 1999). The interpersonal effectiveness component includes clarifying the patient's interpersonal priorities and objectives, and enhancing their assertiveness skills (Wiser et al., 1999). The aim of the mindfulness component is to reduce judgments of the self and others, and to increase awareness and acceptance of experience, particularly emotional experiences. The patient is told to become aware of the experience and view it in an objective, nonjudgmental way, to avoid feelings of guilt and shame that result from critical judgment. It is thought that by practicing mindfulness, the patient will learn that emotional experiences are transitory and represent only a moment in their existing reality. The goal of the second component, distress tolerance, is to increase tolerance of painful affect and decrease maladaptive behavioural responses to the distress. This component teaches the patient to endure highly distressing situations that they are not able to change, and to reduce impulsive, maladaptive behaviour such as binge eating, that is likely to make the situation worse. Distress tolerance is divided into two main sections; crisis survival and acceptance strategies. The crisis survival section involves cognitive and behavioural techniques that serve to attenuate the high level of distress by temporarily diverting the individual's attention away from the stress. The acceptance strategies help the patient to accept the stressor without diverting attention or attempting to change or avoid the situation in any way. During the third component, emotion regulation, the patient is taught to reduce their emotional vulnerability and increase their ability to change their current emotional state. This component aims to help the patients identify various parts of an emotional response, and understand their responses and the reason for them. They are taught to build positive emotional experiences, and to change their emotional states. Self-monitoring techniques are used to record their emotional experiences with the aim of uncovering internal and external triggers that lead to binge episodes. Specific binge episodes are deconstructed to determine the reason it occurred and how it can be prevented in the future, including a full analysis of the emotional, behavioural, and situational antecedents and consequences of the binge. Patients are encouraged to practice all the skills they are taught, to increase the repertoire from which they can draw alternative coping strategies (Wiser et al., 1999).

Preliminary studies evaluating the effectiveness of DBT are currently underway (Wiser et al., 1999). Nevertheless, a single-case study on a 36 year old, caucasian woman with BED showed promising support for the development and standardisation of an emotion regulation treatment strategy for treating BED (Telch, 1997). The therapy lasted for 23 individual, 50 minute sessions that were spread over a ten month period (Telch, 1997). Telch (1997) speculated that DBT or other emotion regulation treatments may benefit the remaining 50% of non-responders to CBT and IPT.

DBT is a long-term therapy that consists of at least 20 sessions and lasts up to ten months (Telch, 1997). It is possible that a shorter, less complex treatment that focuses on emotional intelligence may produce similar results in treating binge eating symptomatology.

RATIONALE

This study is based on a reformulation of the affect regulation model and is influenced by DBT. It will incorporate the concept of emotional intelligence and will be applied to BED.

EMOTIONAL INTELLIGENCE

Emotional intelligence (EI) was a concept that was developed as an equivalent to intelligence quotient (IQ) by Salovey and Mayer in 1990. It was devised with the aim of dealing with the growing dissatisfaction over the “narrowness” of the traditional notion of intelligence that the term IQ engendered (Mayer & Salovey, 1997; Golman, 1995; Salovey et al., 1990).

Emotional intelligence is a type of “social intelligence” (Mayer & Salovey, 1993) and involves emotional recognition in oneself and others, emotional understanding, and emotional management (Ciarrochi, Chan, & Caputi, 2000; Steiner, 1997; Greenberg & Paivio, 1997; Goleman, 1995). It is also the ability to regulate one’s moods and emotions by resisting emotional impulses and controlling them so that they do not inhibit one’s ability to think and act appropriately (Goleman, 1995). Recently, Ciarrochi and associates (2000) documented the distinctiveness and usefulness of the EI construct. Of particular interest, EI was found to correlate significantly with other measures on openness to feelings, and empathy and was related to mood management, although it was noted that future research was needed to determine the exact nature of the relationship between mood management and EI (Ciarrochi et al., 2000).

Alexithymia

Alexithymia is a multidimensional construct used to describe individuals who are unable to appraise and verbally express their emotions (Sifneos, 1972; de Zwann, Bach, Mitchell, Ackard, Specker, Pyle, & Pakesch, 1995; Paez, Basabe, Valdosedá, Velasco, & Iraurgi, 1995) and who have difficulty in distinguishing between feelings and bodily sensations (Taylor, Bagby, Ryan, Parker, Doody, & Keefe, 1988). When it comes to dealing with emotions, those who are alexithymic use inhibitory or avoidance styles of coping (Paez et al., 1995). These features all suggest that alexithymia represents those who lack some essential skills needed in emotional intelligence. Research has documented that individuals with eating disorders are more alexithymic than control subjects (Bourke, Taylor, Parker, & Bagby, 1992; Cochrane, Brewerton, Wilson, & Hodge, 1993; Schmidt, Jiwany, & Treasure, 1993).

ROLE OF EMOTIONS

This thesis is based on the arguments that emotional states precede binge eating (e.g., Abraham et al., 1982; Lingswiler et al., 1989; Arnow et al., 1992; 1995), that women with BED cannot accurately or consistently differentiate emotional states (Johnson &

Connors, 1987), and that they do not cope effectively or adaptively with emotional distress (Kenardy et al., 1996). It will employ a psychoeducational programme that teaches skills in differentiating between emotional states. The programme will also teach effective coping skills, with a particular focus on coping with emotional distress. The aim of this thesis is to determine whether teaching emotional intelligence skills to individuals with binge eating problems will have the effect of reducing their need to binge.

THE PROGRAMME

It is planned to present the programme in a series of group meetings. Each session will end with a homework assignment. This will be to ensure that the participants put into practice the skills they have learnt, and the homework will be checked at the beginning of the following session. There will be frequent group discussions, and overhead projector sheets will be put up so that the participants not only hear the words, but what they hear is reinforced by reading it at the same time.

SELF MONITORING

Self monitoring is a widely used technique in many research studies on binge eating disorder (for instance, Agras, Telch, Arnow, Eldredge et al., 1997; Williamson, Womble, & Zucker, 1998; Agras, 1999; Wilson & Vitousek, 1999). When used correctly, it can provide an accurate and detailed picture of the patient's current eating behaviours, emotional antecedents and emotional consequences (Sarafino, 1996; Schmidt, 1998; Wilson et al., 1999). In instances where patients are ignorant of their eating patterns, it can be used to allow them to become aware of the amount of food they are consuming (Marcus, 1996). Thus, self-monitoring can be used to change binge eating behaviour that may have previously seemed automatic or uncontrollable (Fairburn, Marcus, & Wilson, 1993; Sarafino, 1996). Moreover, it allows researchers and therapists to assess an

individuals progress during treatment (Wilson et al., 1999). It has been found that patients with BED are accurate in reporting food intake when using self-monitoring (Yanovski & Sebring, 1994; Lingswiler, Crowther, & Stephens, 1989; Crowther, Lingswiler, & Stephens, 1984).

Throughout the 11 week programme, the participants will be asked to monitor all their binge episodes and the emotional antecedents and consequences. This will also include the date and time of consumption, the location, the situational variables, and the participants behavioural response to bingeing (see Appendix 7 for an example monitoring sheet).

The first session of the programme involves explaining the purpose of self monitoring and how it can be used to help them gain control of their binge eating problem. It will be explained that self monitoring can not only bring their attention to the factors surrounding their binge eating problem, but it can also make them aware of their behaviour at the time when they are doing it (Sarafino, 1996). Participants will be informed that this could benefit them by allowing them to see where changes need to be made most, and where certain changes may not benefit them at all. It will also be made clear that honesty, accuracy, persistence, and recording information immediately after the event are essential to maximising the benefits of self monitoring (Sarafino, 1996). Lastly, the self monitoring forms will be explained in detail, including an outline of the purpose of each column. The self-monitoring session is taught before the participants begin monitoring so that it can be put to its best use from the beginning.

The participants will be given fourteen self monitoring sheets for the first two weeks. A filled in example of the self monitoring form will also be provided and explained in detail. Lastly, they will be given a programme outline form that includes a commitment statement for them to sign and keep. The participants will be told that they will not meet with the group again for another two weeks.

OVERVIEW OF BINGE RECOGNITION

The overview of binge recognition will be the first half of the second session. This will be provided so that the participants can get a clear idea of how binge episodes are defined. The binge recognition component will be taught after the first session on self-monitoring and the two weeks of baseline for two reasons. Firstly, it is possible that teaching the binge recognition session before asking the participants to record their baseline behaviours may bias the results. Secondly, recording all food consumed will allow the author to measure all binge episodes.

It has often been noted in the literature that there are discrepancies in how binges are defined (Telch & Agras, 1996). Thus, participants will be asked to record all food that they consume during baseline, including all meals, snacks and binges, and to put an asterix next to the foods they consume that they consider a binge. It will be expected that this will help participants and the author get a better idea of the actual occurrence of their binge episodes, and the author can detect any discrepancies in binge definition.

After this session participants will be asked to record only their binges episodes, and not every meal as they have been doing for the last two weeks. This will ensure the participant is more likely to continue self-monitoring as they do not have to record every thing they eat.

BASIC NUTRITION COMPONENT

Although those with binge eating problems do not binge in relation to hunger (American Psychiatric Association, 1994), it was considered that a basic nutrition component was necessary. It has been argued that they not only eat more during normal meals (Yanovski, Leet, & Yanovski, 1992), but they may not realise the value in eating regularly (Peterson & Mitchell, 1996). According to Agras (1995), therapists should help the patient reduce

the length of time between their meals, expand their food choices, and should help patients choose foods with lower fat contents.

The participants will be asked to record the times of which they eat their meals so that they can get used to the idea of taking note of the times they consume their meals, in addition to noting risk times for binge episodes. In the basic nutrition session, it will be explained that to obtain the maximum benefit from food, meals and snacks are best eaten within two to four hours of each other. Participants will be asked to reflect on how frequently they are eating their meals and snacks. They will then be taught how to organise and schedule their meals if they do not eat within every two to four hours already. An outline of a typical plan will be devised group discussion, and will be written on a white board to ensure participant understanding. It will be explained that putting this new skill into practice will benefit them and their binge eating problem.

Additionally, basic food nutrients will be covered, including food portioning. An example of a typical daily meal plan will be given. The plan will be deconstructed into nutrition components, and explained to the participants. A diagram explaining food portions will be given out so that participants can take this home and devise a meal plan for themselves in their own time.

Lastly, behavioural lengthening strategies will be covered. It will be explained that urges to binge can be curbed through distraction techniques. Participants will be asked to devise at least five techniques of their own to curb their urges to binge.

EMOTIONAL RECOGNITION COMPONENT

The emotional recognition component will be divided into two sessions. This is to allow an extensive coverage of individual emotions and their influence on binge eating and life generally.

Emotional Influence on Binge Eating and Life Generally

This session will cover how emotions influence binge eating problems, and which specific emotions most commonly precipitate binge episodes. The reasons for eating in response to emotions will be discussed, as will the negative consequences of using food to cope with emotional distress.

The reasons for emotions will be covered in terms of their biological purposes. This will be accompanied by a description of the physiological changes that occur during happiness, love, fear, surprise, anger, and sadness. It will be argued that it is not helpful to one's psychological well being and health to view emotions as problematic.

The participants will then be asked to consider and write for five minutes on how they feel after binge eating, and how they feel, or might feel, after resisting the urge. The aim of this exercise is two-fold. The first aim is to get the participants to consider how they are feeling emotionally after a typical binge. It is expected that they would normally suppress or ignore their emotions during and after binge episodes, and, as yet, are probably not aware of how they feel after one. The second aim is to get them to compare how they feel after bingeing, and how they feel after resisting. Once they are aware of them, the negative emotional consequences of bingeing will act as a punisher and make future binges less likely. Resistance, however, will have positive emotional consequences, which will act as a reinforcer for resisting in the future.

A brief overview of emotional intelligence will also be covered, and will be discussed in terms of how it will benefit their binge eating problem.

Emotional Discrimination

This session will describe what an emotion is, and how they can be recognised. A detailed description of the physiological changes and biological purposes will be covered again to remind the participants. In addition, the psychological characteristics, the

situational and cognitive variables that can cause emotions, along with the behavioural aspects and facial expression of emotions will be covered extensively.

An introduction to emotion management will be given, along with a brief description of effective techniques for expressing and communicating emotions.

EMOTIONAL MANAGEMENT COMPONENTS

The emotional management components will be relaxation training, problem solving skills, and assertion training.

Relaxation Training and Differential Relaxation Training

Stress often accompanies emotional distress and may also trigger binge episodes (Heatherton, 1991; Greeno & Wing, 1994; Crowther, Sanftner, Bonifazi, & Shepherd, 2001). Thus, binge eating can be thought as a coping response to stress (Telch, 1997; Peterson et al., 1996; Abraham & Llewellyn-Jones, 1995), or as a maladaptive emotion-regulation strategy (Wiser & Telch, 1999). Relaxation training will be given so that the participants will have an alternative coping response they can use to deal with emotional distress and stress without binge eating.

The session will start with a group discussion on the importance of relaxation in gaining control over emotional distress and binge eating problems. Three techniques will be taught, and the relaxation component will run over two sessions. Progressive Relaxation, based on an outline presented by Sarafino (1996), will be taught in the first session, and a reminder will be given in the second session. The first session will end with deep breathing exercises, which will also be repeated in the second session. The third type of relaxation that will be covered will be differential relaxation skills. This will be taught only in the second session.

Problem Solving Skills

Binge episodes are often precipitated by adverse affect, often provoked by an external problem (Fairburn, Marcus, & Wilson, 1993). It has been suggested that disordered eating behaviour can be reduced by replacing ineffective coping styles, such as emotion-focused coping, with more effective coping styles, such as problem-focused coping (Loro & Orleans, 1981; Shatford & Evans, 1986). Emotion-focused coping involves taking efforts to reduce negative emotional reactions to stress, such as by distracting oneself from the problem, seeking comfort from others, or using relaxation. Problem-focused coping involves taking direct action to solve the problem, or seeking information that will be relevant to the problem (Davison & Neale, 1998). Although both may be effective in dealing with different problems, emotion-focused coping is the least effective way of dealing with daily problems or chronic problems that can be changed (Davison et al., 1998). Individuals with binge eating problems are thought to use avoidance coping to deal with stress (Paxton & Diggins, 1997; Wilfley et al., 1997; Yanovski, Nelson, Dubbert, Spitzer, 1993), rather than more adaptive coping techniques.

Firstly, the association between problems and emotions will be discussed in relation to binge eating. In addition, emotion-focused and problem-focused coping will be covered. The session will end with two problem solving techniques that can be used to help cope with stress. The first will be a seven step problem solving strategy (adopted from Sarafino, 1996). This will include problem recognition and definition, brain storming of solutions and evaluation of each solution, selecting the most appropriate solution, enacting the solution, and evaluation of the solution after it has been tried. The other is the use of writing using the self-regulation writing task.

The Self-Regulation Writing Task

The self-regulation writing task involves writing about one's thoughts and feelings regarding a stressful event, and selecting ways in which one can cope with the stressful situation (Cameron & Nicholls, 1998). Rather than simply writing as a way to vent emotions, this technique involves focusing on selecting, enacting, and appraising

different ways of coping with a particular problem (Cameron et al., 1998). This technique was introduced into the programme so that the participants will be able to make sense of the events that cause stress, and to enable them to cope with it better.

The participants will be asked to write for 15 minutes about their deepest thoughts and feelings regarding a recent stressful event that may have led to a binge, or could have potentially led to a binge. They will then be asked to list three things they can do to cope with the problem. This exercise will be done either during the session, or later at home depending on time limits. Lastly, they will be asked to select one solution or coping response and put it into practice during the following week.

Assertion Training

Those with binge eating problems often have interpersonal skill deficits (Wiser & Telch, 1999; Telch & Agras, 1994; Arnow, Kenardy, & Agras, 1992) and may use more negative coping strategies in stressful interpersonal situations (Hansel & Wittrock, 1997). In addition, the negative affect that often precipitates binge episodes is often triggered by interpersonal interactions (Heatherton et al., 1991). It has been suggested that binge eating also provides an effective means of avoiding interpersonal conflict and rejection (Peterson et al., 1996). Assertive training is often used in treatments for binge eating problems (e.g., Peterson, Mitchell, Engbloom, Nugent, et al., 2001; Telch, 1997; Peterson et al., 1996). It will be given after the problem solving session as it can be thought of as a type of problem-focused coping strategy.

As assertion training is relatively complex, it will be covered over two sessions. In the first session, the purpose of the training will be explained in relation to how it can help them gain control over their interpersonal conflicts and relations, and subsequently their binge eating problem. Assertive behaviour and nonassertive behaviour will then be discussed, including a definition of passive, aggressive, passive-aggressive, and manipulative behaviour. A brief overview on self-talk and how it relates to their interpersonal skills will then be given. The participants will then be taught how to be

assertive, how to say “no”, and how to avoid manipulation. A copy of *Personal Bill of Rights* (adopted from Bourne, 1995) will be given out.

In the second session, making requests and practicing assertive responses will be covered. A summary of how to act assertively will be given. Lastly, participants will be asked to select a recent social interaction that they found stressful that did or could have led to a binge episode. The group will devise and discuss alternative assertive responses for each situation.

MAINTENANCE SESSIONS

Despite the effectiveness of various treatments, one of the notable limitations of many of the existing treatments for binge eating problems is that the treatment effects do not last. Thus, this programme includes a large section on maintenance of treatment effects and relapse prevention.

The maintenance section will be covered over two weeks, beginning with a review of the programme. The participants will firstly be reminded of the topic of each session, and will then be asked to mention any problems they have with understanding throughout the programme. This will be followed by a summary of each session, and how the participants can use the skills they have learnt from each session at any time in the future. They will be asked if they have used the skills they have been taught in each session other than when they were asked to for their homework assignment. Those that have will be asked to describe how it benefited them. Those that have not will be asked to explain why not, and will be reminded that everything they have learnt must be practiced to be of any benefit to their binge eating problem.

The second maintenance session is a preventative problem solving component. Each participant will be asked to identify at least one situation that they can see might be a threat to their psychological well being and health. Each person in the group will then be

asked to offer a possible coping response from those that they have learnt throughout the programme that will help them avoid resorting to binge eating. Each solution will be evaluated for possible positive and negative consequences, and the participant who suggested the problem will decide on the best response for them. It will be suggested that they write down the problems that they can relate to, and the solutions that have been offered. This is so that they have something to refer to and remind them of their options for coping with future problems.

The participants will then be given a form that summarises the skills they have learnt in each session. When the participants have the urge to binge, they can review and put into practice all the skills they have learnt throughout the programme.

Lastly, the maintenance sessions will be ended with handing the self-monitoring forms back to the participants so that they can review the progress they have made. Each participant will be shown a graph that illustrates their personal progress, to make reviewing their improvements easier. Although the participants will not keep their self-monitoring forms, this exercise will be expected to motivate and reinforce them to keep up with the improvements they have made.

CHAPTER 2: METHOD

PARTICIPANTS

RECRUITMENT

Participants were recruited through several methods of advertising. Advertisements were posted around the University of Canterbury and in the College of Education (see Appendix 1). In addition, a 200 word editorial outlining binge eating problems with an accompanying advertisement was printed in the local news paper, *The Mail*, which is circulated to the majority of Christchurch residents (see Appendix 2). Due to high attrition rate, a second smaller advertisement was placed in *The Mail* to recruit participants for the third group.

SELECTION

Participants were initially invited to come to the University of Canterbury to fill in the Binge Eating Scale (Gormally, Black, Daston, & Rardin, 1982) and the Questionnaire on Eating and Weight Patterns (Spitzer, Yanovski, Wadden, Wing et al., 1993). Of the 54 who rung to find out more information about the programme, a total of 22 turned up to answer these questionnaires. Those who scored greater than the cut-off of 27 on the BES (as recommended by James Gormally, in personal correspondence, 14.05.2001), and who met all of the criteria outlined by Spitzer and associates (1993) for the QEWP were chosen to attend the programme. Due to the fact that the programme was intended to help those with binge eating problems and not binge eating disorder, those who scored close to the cut-off of 27 on the BES (Gormally et al., 1982) and met all the criteria for the QEWP (Spitzer et al., 1993) were also chosen. Those who did not fill in all the answers required on either questionnaire were not chosen to attend the programme. Those who appeared to

display symptoms for bulimia nervosa (as outlined by Spitzer and associates, 1993, for evaluating the QEWP) were sent a letter outlining the findings (see Appendix 5). Additionally, they were advised to consult their physician if they wanted to receive help and further advice concerning these findings.

Participants were allocated into groups on the basis of their availability, rather than random selection. A total of six participants were allocated to the first group, four were allocated to the second group, and three were allocated to the third group. After the first two weeks, one participant in group one declined further involvement in the programme due to work commitments, and one participant in group three declined further involvement due to personal reasons.

DATA COLLECTION PROCEDURE

Data was collected at baseline, post-intervention, and at follow-up. Group one and group two were measured at 3 months follow-up, and group three was measured at 2 months follow-up due to time constraints.

MEASUREMENTS

THE BINGE EATING SCALE (Gormally, Black, Daston, & Rardin, 1982)

Initially, participants filled in the BES and the QEWP. The Binge Eating Scale (Gormally et al., 1982) is a standard self-report measure that assesses binge eating disorder. It is a 16-item questionnaire, with item scores ranging from zero to three. Each question has

four options, and scoring depends on the weighting the authors gave each option. The scale was designed to determine the presence of cognitive and behavioural characteristics of binge eating. Body satisfaction, ability to control the amount and speed of eating, cognitions concerning food, emotions and eating, and emotional consequences of eating are measured. The BES has been widely used in research on binge eating disorder (Gladis, Wadden, Foster, Vogt, et al., 1998).

QUESTIONNAIRE ON EATING AND WEIGHT PATTERNS ® NZ (Spitzer, Devlin, Walsh, Hasin, et al., 1992)

The Questionnaire on Eating and Weight Patterns (Spitzer et al., 1992) is also a standard self-report questionnaire which measures binge eating and bulimic symptoms. The revised version consists of 28 questions (Spitzer, Yanovski, & Marcus, 2001), which are scored in accordance with criteria that are outlined by the authors. The questions were modified slightly to fit into New Zealand dialogue to make it easier for the participants to answer. The options for their ethnic/racial background were changed from “Black, Hispanic, White (not Hispanic), Asian, and Other” to “New Zealand European, Maori, Pacific Island, Asian, and Other”. Changes were also made to the question regarding educational background. Instead of the original options “grammar school, junior high school or less, some high school, high school graduate or equivalency (GED), some college or associate degree, and completed college”, participants were given the options “school certificate or equivalent, sixth form certificate, high school graduate, and university, polytechnic, or other tertiary degree or diploma”. Local brand names were used in question 14, which asks the participants to list everything they might have eaten in a recent binge episode. For instance, rather than “Ruffles chips”, “Ripples chips” were offered as an example. Changes were also made to measurement options. Rather than asking how tall they were in terms of feet and inches, participants were asked how tall they are in centimetres. In addition, all references to ounces and pounds were converted to equivalent kilograms.

In addition, changes were made to the time frame in which participants were asked if they often ate within any two hour period what most people would consider an unusually large amount of food.. For this question and any others relating to recent binge episodes, the original time frame of six months was kept the same before the programme was administered, but the time frame was changed from six months to two months immediately following the end of the programme, and at follow-up (see Appendix 4 for an example). This is because the programme lasted a total of 11 weeks when the two weeks of baseline measurement are included. If the participants were to answer the questions concerning their last binge episode during the original time frame of six months, this would have to include the four months prior to their partaking in the programme. Thus, they would still fit the criteria for binge eating disorder even if they had not had a recent binge episode.

Although the validity of both devices has been established, a study by Gladis and associates showed that they have a low level of agreement between them (Gladis, Wadden, Vogt, Foster et al., 1998). For this reason, both were used to assess binge eating problems, and were not used as diagnostic tools. All participants who fitted the criteria for binge eating problems in both questionnaires were selected to take part in the programme. In addition, those who fitted all the criteria for binge eating disorder according to the QEWP, and who scored just below the cut-off score on the BES for binge eating disorder were also chosen.

Participants who were selected to attend the programme filled in the COPE (Weinman, Wright, & Johnston, 1989), the Perceived Stress Scale (Johnston, Wright, & Weinman, 1983), the Toronto Alexithymia Scale (Kroner & Forth, 1995), the Emotional Intelligence Scale (Slovely, Meyer, Schutte, Malouff, Haggerty, Cooper, Golden, & Dornheim, 1997), and the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995). They also responded to scenarios presented in accordance with the Activated Thoughts and Simulated Situations (Davidson, Robins, & Johnson, 1983) techniques.

THE DEPRESSION-ANXIETY-STRESS SCALES (Lovibond & Lovibond, 1995)

The Depression-Anxiety-Stress scales (Lovibond & Lovibond, 1995) were used to assess the participants' levels of depression, anxiety and perceived stress. It is a 42-item scale in which questions regarding depression, anxiety and perceived stress are randomly ordered. Items are scored from zero to three, in which zero is the lowest value. Depression, anxiety and perceived stress are scored by adding the values the participant assigns to the question. The scores are then converted to z-scores for a comparison between the scales answered by the participant relative to the norms that are supplied by the authors.

In a comparison examination, the DASS was found to correlate highly with the Beck Depression and Beck Anxiety Inventories (Lovibond & Lovibond, 1995). In addition, the study found that the three scales of the DASS had satisfactory reliability. While it discriminated between the three negative affective states, as expected there was a moderate correlation between the three syndromes (Lovibond et al., 1995). However, unlike the BDI and the BAI, the DASS does not include symptoms that fail to discriminate between depression and other affective disorders (Lovibond et al., 1995). For this reason, the DASS was chosen for this study over the BAI and the BDI. Further, this provided the added benefit of giving the participants only one questionnaire to fill in rather than two.

THE PERCEIVED STRESS SCALE (Cohen, Kamarck, & Mermelstein, 1983; Johnson et al., 1995)

The Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983; Johnson et al., 1995) was used to measure the "degree to which situations in one's life are appraised as stressful" (Cohen et al., 1983; Johnson et al., 1995). Stress is measured in a one-month time frame using a 14-item scale, a 10-item scale, and a 4-item scale that is suitable for phone interviews. Although no specific categories or cut-offs are suggested by the author (Johnson et al., 1995), means, standard deviations and score ranges for all three scales

have been supplied. In order to obtain means and standard deviations, Cohen and Williamson (1988), randomly interviewed 2,387 people by phone. This study used the PSS-14 to assess participant's perceived stress, the mean score of which is 19.62 and the standard deviation is 7.49. The PSS-14 has good internal consistency (Cohen et al., 1993; Johnson et al., 1995) and better predicts future physical symptomatology than life event measures (Johnson et al., 1995).

THE COPE (Carver, Scheiver, & Weintraub, 1989; Johnson, Wright, & Weinman, 1995)

The COPE (Carver, Scheiver, & Weintraub, 1989; Johnson, Wright, & Weinman, 1995) was used to assess participants' coping strategies. It is a multidimensional questionnaire and includes 13 categories that are conceptually distinct. These are active coping (taking action, and exerting efforts, to remove or circumvent the stressor), planning (thinking about how to confront the stressor, planning one's active coping efforts), seeking instrumental social support (seeking assistance, information, or advice about what to do), seeking emotional social support (getting sympathy or emotional support from someone), suppression of competing activities (suppressing one's attention to other activities in which one might engage, in order to concentrate more completely on dealing with the stressor), turning to religion (increased engagement in religious activities), positive reinterpretation and growth (making the best of the situation by growing from it, or viewing it in a more favourable light), restraint coping (coping passively by holding back one's coping attempts until they can be of use), acceptance (accepting the fact that the stressful event has occurred and is real), focus on venting of emotions (an increased awareness of one's emotional distress, and a concomitant tendency to discharge those feelings), denial (an attempt to reject the reality of the stressful event), mental disengagement (psychological disengagement from the goal with which the stressor is interfering, through day-dreaming, sleep, or self-distraction), and behavioural disengagement (giving up, or withdrawing effort from, the attempt to attain the goal with which the stressor is interfering) (Johnson et al., 1995).

The participants' alcohol/drug use and use of humour as coping strategies have recently been added, but are considered exploratory (Johnson et al., 1995). Carver and associates (1989) hypothesised that active coping, planning, seeking instrumental social support, positive reinterpretation and growth, and acceptance are adaptive in situations where active coping is linked to a positive outcome (Johnson et al., 1995). While seeking emotional social support, suppression of competing activities, and restraint coping are less obviously associated with active coping, they were nonetheless thought to be adaptive coping responses (Johnson et al., 1995). Focusing on and venting of emotions, denial, and behavioural disengagement were considered maladaptive in situations where active coping is necessary (Johnson et al., 1995). However, these responses were not considered intrinsically maladaptive as the authors argued they may be particularly valuable in many health-related situations (Johnson et al., 1995).

The COPE has been written in two versions so that it can be used to measure situational or dispositional coping responses, or both (Johnson, Wright, & Weinman, 1995). Situational coping is responses to specific situations or specific periods, while dispositional coping is the participant's usual response to stressors (Johnson et al., 1995). It has been found that the internal consistency the COPE scales is acceptably high (Carver et al., 1989; Johnson et al., 1995). However, the "mental disengagement" scale is less likely to be internally consistent as it is made up of a number of diversified items (Johnson et al., 1995). It was also found that the coping tendencies measured by the dispositional version of the COPE scale were reasonably stable (Johnson et al., 1995). Although this scale does not include assessments of social comparison, wishful thinking, or allocation of blame (which were used in previous coping scales, see McCrae and Costa, 1986), participants were given the dispositional version due to the fact that it assesses a wide range of coping responses.

THE EMOTIONAL INTELLIGENCE SCALE (Schutte, Malouff, Hall, Haggerty, et al., 1998)

The Emotional Intelligence scale (EI; Schutte, Malouff, Hall, Haggerty, et al., 1998) was used to assess the participants' current levels of emotional intelligence. The EI was developed in accordance with the theoretical model outlined by Salovey and Mayer (1990; Schutte et al., 1998). Schutte and associates constructed the 33-item scale from a total pool of 62 items. Of the total 33, 13 items measured appraisal and expression of emotion, 10 measured emotion regulation, and 10 measured utilisation of emotion (Schutte et al., 1998). Items were scaled on a 5-point scale, on which 1 represented "strongly disagree", and 5 represented "strongly agree." The 33-item emotional intelligence scale has been found to have good internal consistency and test retest reliability (Schutte et al., 1998). The authors suggest that the scale is best used in research that explores the nature of emotional intelligence, in particular whether emotional intelligence can be enhanced (Schutte et al., 1998).

THE TORONTO ALEXITHYMIA SCALE (Parker, Bagby, Taylor, Endler, et al., 1993)

The 20-item Toronto Alexithymia Scale (TAS-20; Parker, Bagby, Taylor, Endler, et al., 1993) was used to measure the participants' level of alexithymia. The 20-item scale was based on the original 26-item scale (TAS-26; Taylor, Ryan, & Bagby, 1985). Although the TAS-26 demonstrated good internal consistency and test-retest reliability, it was found that the factor "daydreaming" had low magnitude corrected item-total correlations with the full TAS (Bagby, Parker & Taylor, 1994). It has been speculated by other investigators that daydreaming did not adequately contain all aspects of imaginal activities (Bagby et al., 1994). In addition, it was also suggested that self report of daydreaming may have been confounded by a social desirability response bias (Bagby et al., 1994).

The TAS-20 measures three factors. Factor one is difficulty identifying and distinguishing between feelings and bodily sensations, factor two is difficulty describing

feelings, and factor three is externally-oriented thinking. The items were scaled from 1 to 5, where 1 represented “strongly disagree” and 5 represented “strongly agree”. Items 4, 5, 10, 18, & 19 were reverse scored. The TAS-20 uses a more conservative cut-off score than the TAS-26 for identifying alexithymic participants (Taylor, Parker, Bagby, & Bourke 1996). This study employed the empirically derived cut-off score of less than or equal to 61, which was adopted from Taylor and associates (1996). The TAS-20 demonstrated good internal consistency and test-retest reliability (Bagby et al., 1994), and there was evidence of convergent and discriminant validity (Bagby, Taylor, & Parker, 1994 (b).)

ACTIVATED THOUGHTS AND SIMULATED SITUATIONS PARADIGM (Davidson, Robins, & Johnson, 1983)

Activated thoughts and simulated situations (ATSS; Davidson, Robins, & Johnson, 1983) was used to measure the participants’ thoughts and reactions to situations that were presented to them. The ATSS paradigm was devised in an attempt to determine whether problems develop as a result of irrational thoughts or negative self-talk (Davidson et al., 1983). It was also devised so that no information is missed (Davidson et al., 1983), responses are open ended (Davidson, Vogel, & Coffman, 1997) and that responses are as spontaneous as possible (Davidson, et al., 1997). Questionnaires, in contrast, can miss some thoughts by leaving important categories out, or can prompt thoughts as categories can be misleading or suggestive (Davidson et al., 1983). Moreover, Davidson and associates (1983) suggest that speaking is closer to thought than writing for some individuals. Thus, through speech, participants may attempt to express ideas or thoughts that are more complicated and/or subtle than they otherwise would in writing (Davidson et al., 1983). ATSS has also been found to be a better predictor of relapse at extended follow-ups of smoking cessation (Haaga, 1989), and ATSS tapes allow for a direct comparison between emotion-evoking and neutral situations (Davidson et al., 1997).

In ATSS, participants are told that the tape involves listening to the first part of a scenario, pausing the tape to allow for them to verbally respond to the situation, listening

to the second part of the same scenario, and then pausing the tape to verbally respond to the rest of the scenario etc. They are given control of when to restart the tape so that they do not attempt to fill in the allowed time with unimportant or irrelevant information, and so that they do not miss out information if the allowed time is too short. Participants are also told that the researcher is interested in the types of thoughts and feelings they have, and what they would or might do in response to the situation as it occurs. They are also instructed to imagine they are in the scenario as much as possible, to allow for honest responses that represented reality as much as possible. Their verbalisations are recorded on tape and typed into a transcript at a later date.

Although the ATSS paradigm used by Davidson and associates (1983) employed scenarios that were stressful and directly relevant to the participant, the scenarios presented in this study were stressful but not necessarily always relevant to each individual participant. This is because we were interested in their responses to all types of scenarios, and whether their responses would change after they had participated in the programme. Three neutral scenarios were presented, followed by ten emotion-evoking scenarios, and ended with two further neutral scenarios. This was done so that direct comparisons of responses could be made between the scenarios that were intended to evoke an emotional reaction, and those that were not. Each scenario was presented in two or three blocks, so that part of the scenario was presented, the message pauses to allow the participant to stop the tape and respond, and the rest of the scenario was presented ending in another pause for the participant to respond.

An example of one of the neutral scenarios that was presented stated

Imagine you wake up in the morning, and realise you have no bread for toast. It's a warm, sunny day, and the nearest dairy is just across the road. [Pause].

You grab your wallet and make a quick trip to the dairy to buy a loaf of bread still warm from the oven. While you make breakfast, you can smell the warm bread and the fresh coffee.

An example of one of the emotion-evoking scenarios stated

Imagine you have worked for a company for three years. You turn up to work early every day, you are always well presented, and you always perform the tasks that are expected of you to the best of your ability. [Pause].

One day, a valuable piece of stationery goes missing. You saw the person take it, but they don't know you saw them. There is a great upheaval in the office, and eventually your boss accuses you of stealing the item.

CHAPTER 3: RESULTS

RESULTS

ATTRITION RATES

Of the 54 women who responded to the advertisement, a total of 22 turned up to answer the questionnaires. Three women presented bulimic symptoms, and were sent a letter outlining the findings. A total of 11 women were selected for Groups One and Two, but one declined further involvement in the programme due to work commitments. Of the five women who responded to the second advertisement, only two turned up to answer the questionnaires. After the first week of the programme one of the two participants declined further involvement for personal reasons. One from the first advertisement and one from the second advertisement made up Group Three. This left a total of 11 women attending the programme.

DEMOGRAPHIC DATA

Two participants were of desirable weight, one was overweight, and eight were obese. All participants identified themselves as being New Zealand European in ethnicity.

Table 1: Demographic Data

	GROUP ONE	GROUP TWO	GROUP THREE
AGE	34, 38, 49, 68, 48	28, 69, 37, 42	46, 36
WEIGHT CATEGORY	35.3, 23.7, 37, 27.3, 35.2.	31.2, 36.4, 42.2, 41.	22.8, 31.56.

Where <20 is underweight, 20-25 is desirable weight, 25-30 is overweight, and 30 and over is serious obesity.

SELF-MONITORING RESULTS

A multiple baseline design across participants in groups was used. The first group consisted of five participants, Group Two, of four participants, entered the study two weeks later. The third group, consisting of two participants, began the programme four weeks after the first, and two weeks after the second group. Each group remained in baseline for two weeks, before participating in the programme. A full summary of the descriptive statistics for the weekly binge frequencies during baseline and intervention for each group can be viewed in Appendix 8.

The results revealed a decrease in the frequency of weekly binge episodes from baseline to the end of the programme, a trend which was especially evident in the first and third groups (see Figures 1 and 3, on pages 57 and 58). Although the second group did show a decreasing trend (see Figure 2, on page 57), the reduction was not as great as the participants in this group did not engage in binge episodes as frequently at baseline as the participants of the other two groups. This variability in baseline bingeing levels was unavoidable however, as the groups could not be randomly assigned due to availability constraints.

Figure 1: Weekly Mean Frequencies of Binge Episodes for Group One

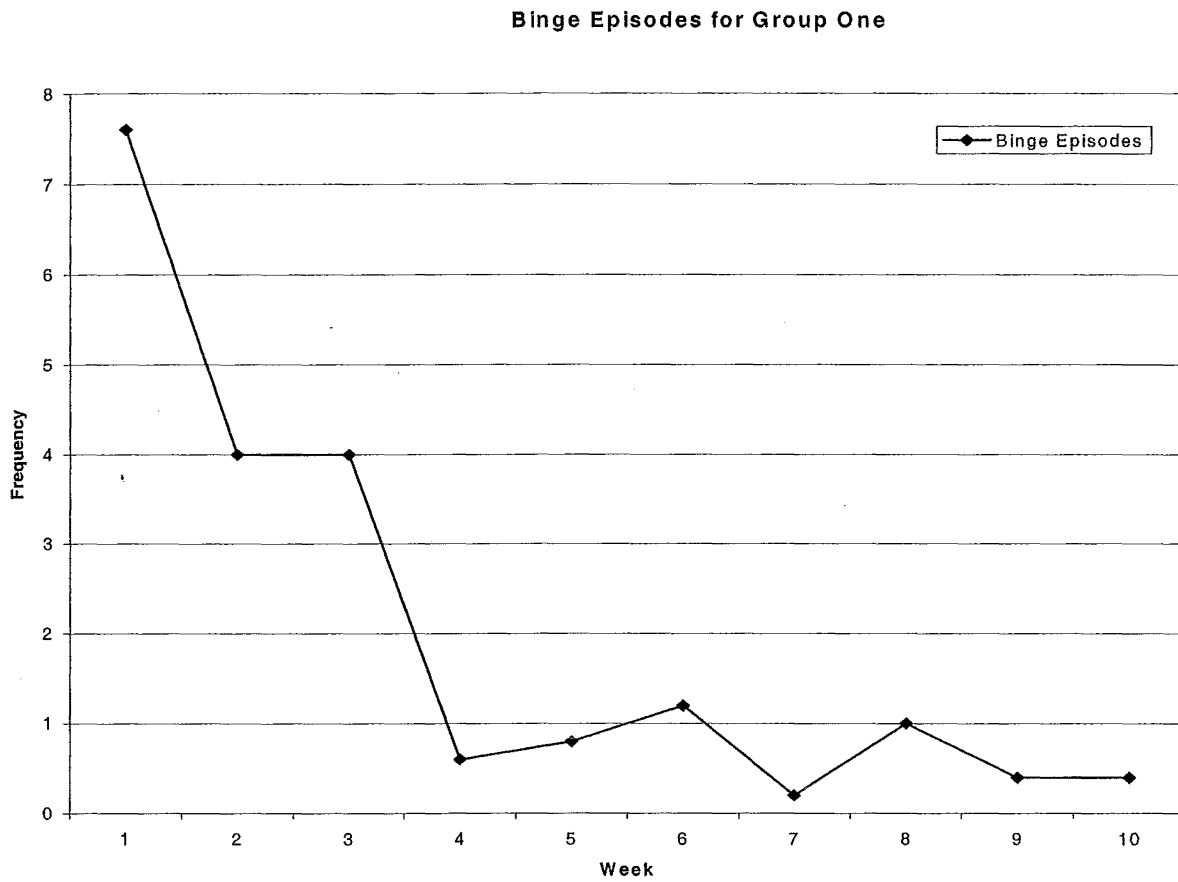


Figure 2: Weekly Mean Frequencies of Binge Episodes for Group Two

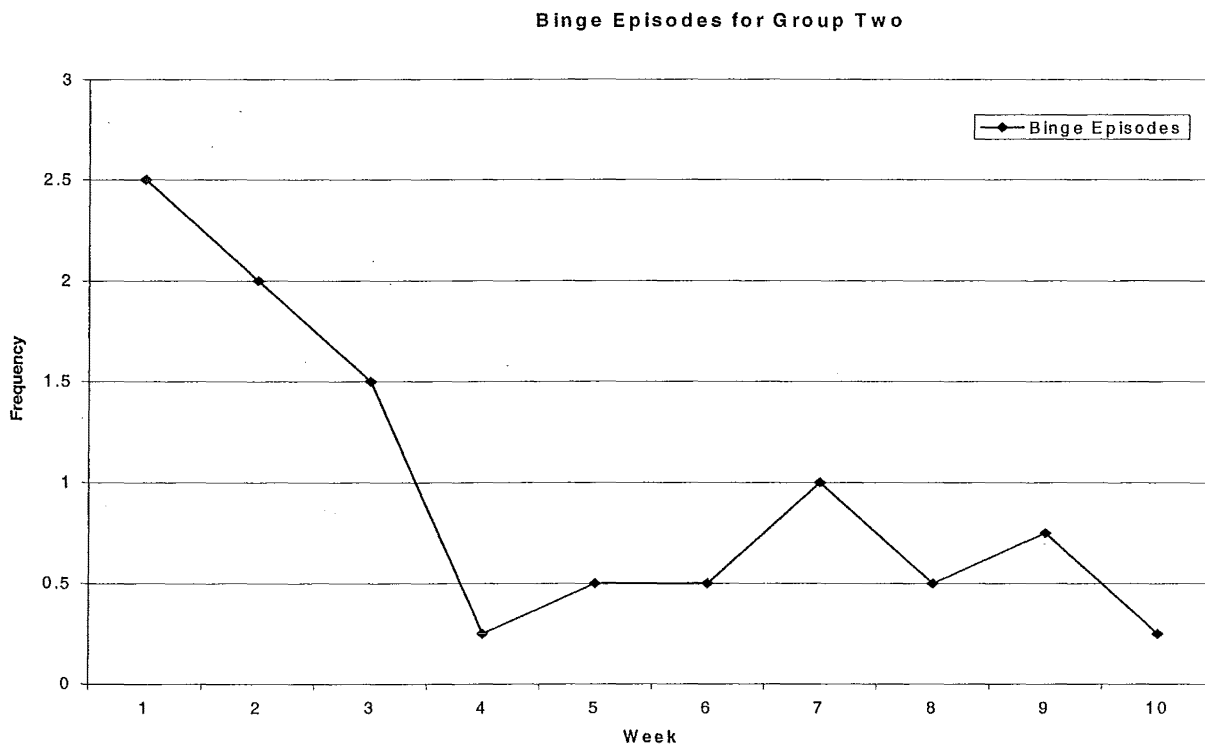
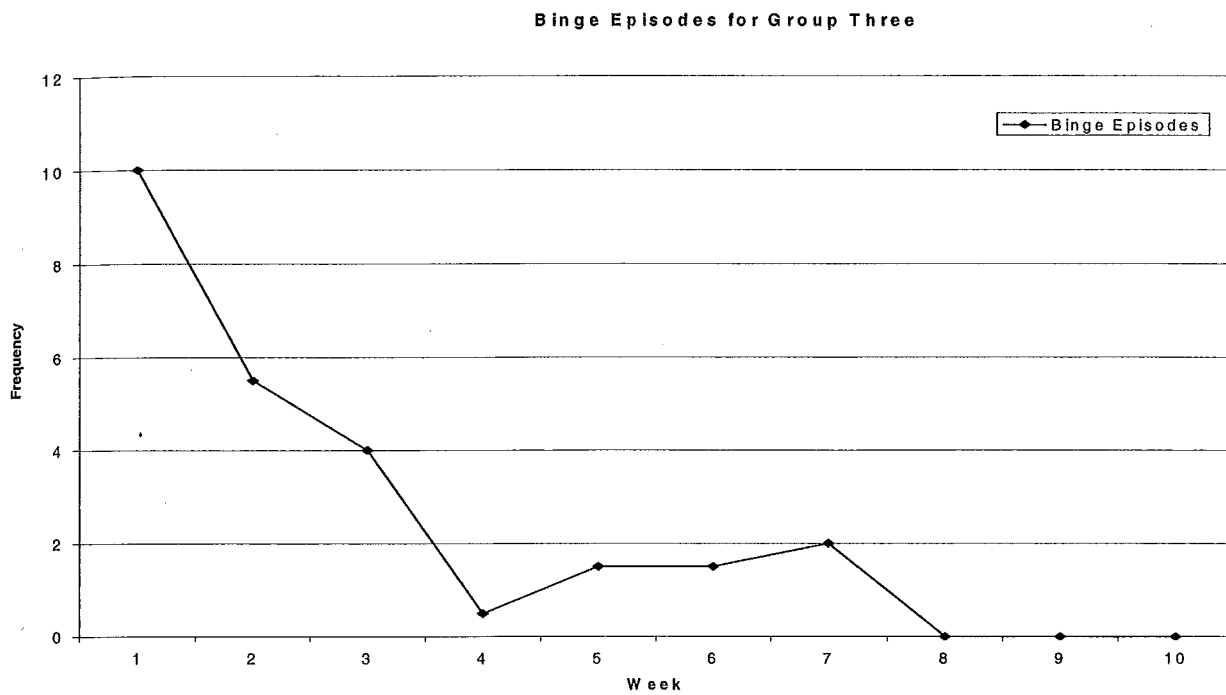
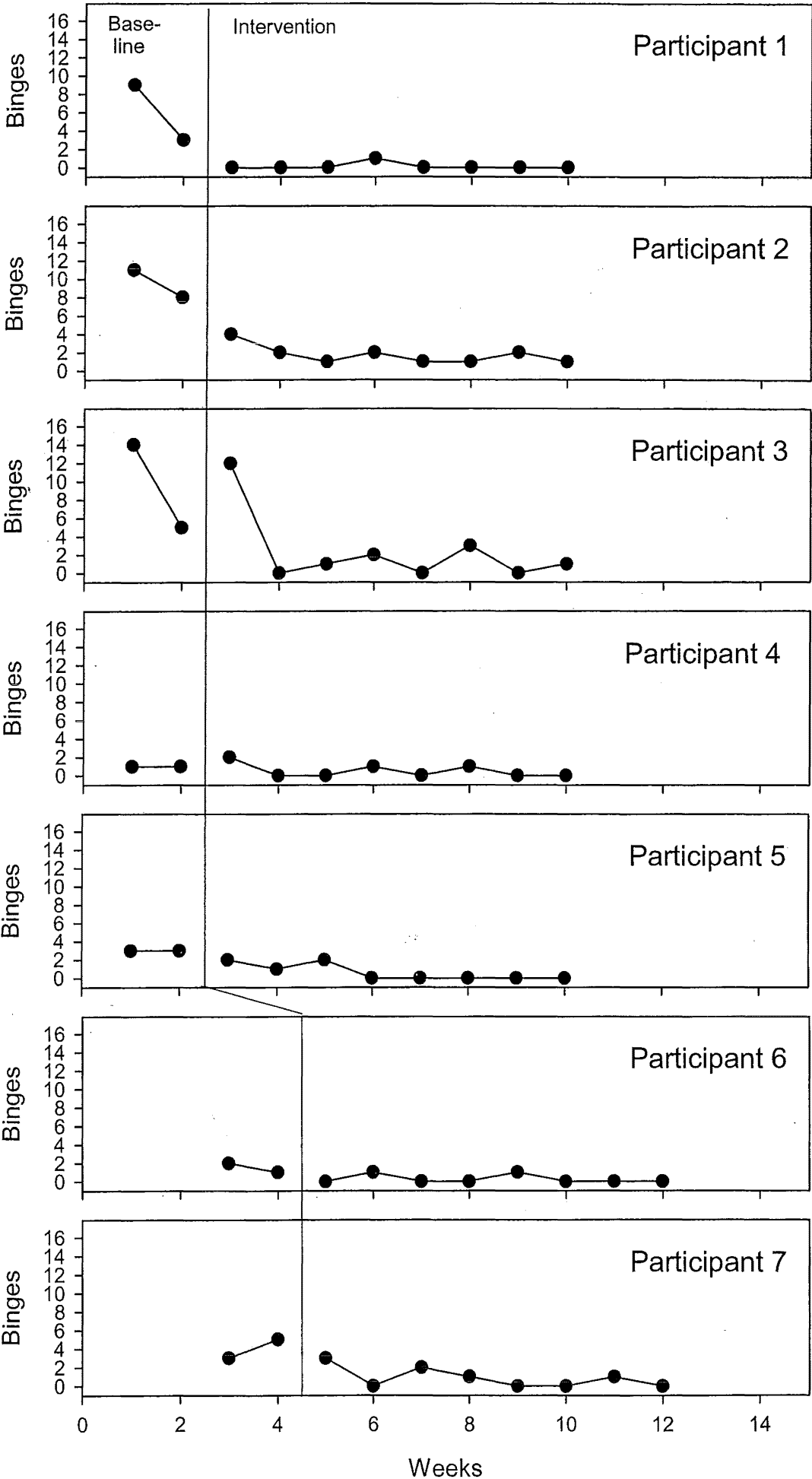


Figure 3: Weekly Mean Frequencies of Binge Episodes for Group Three



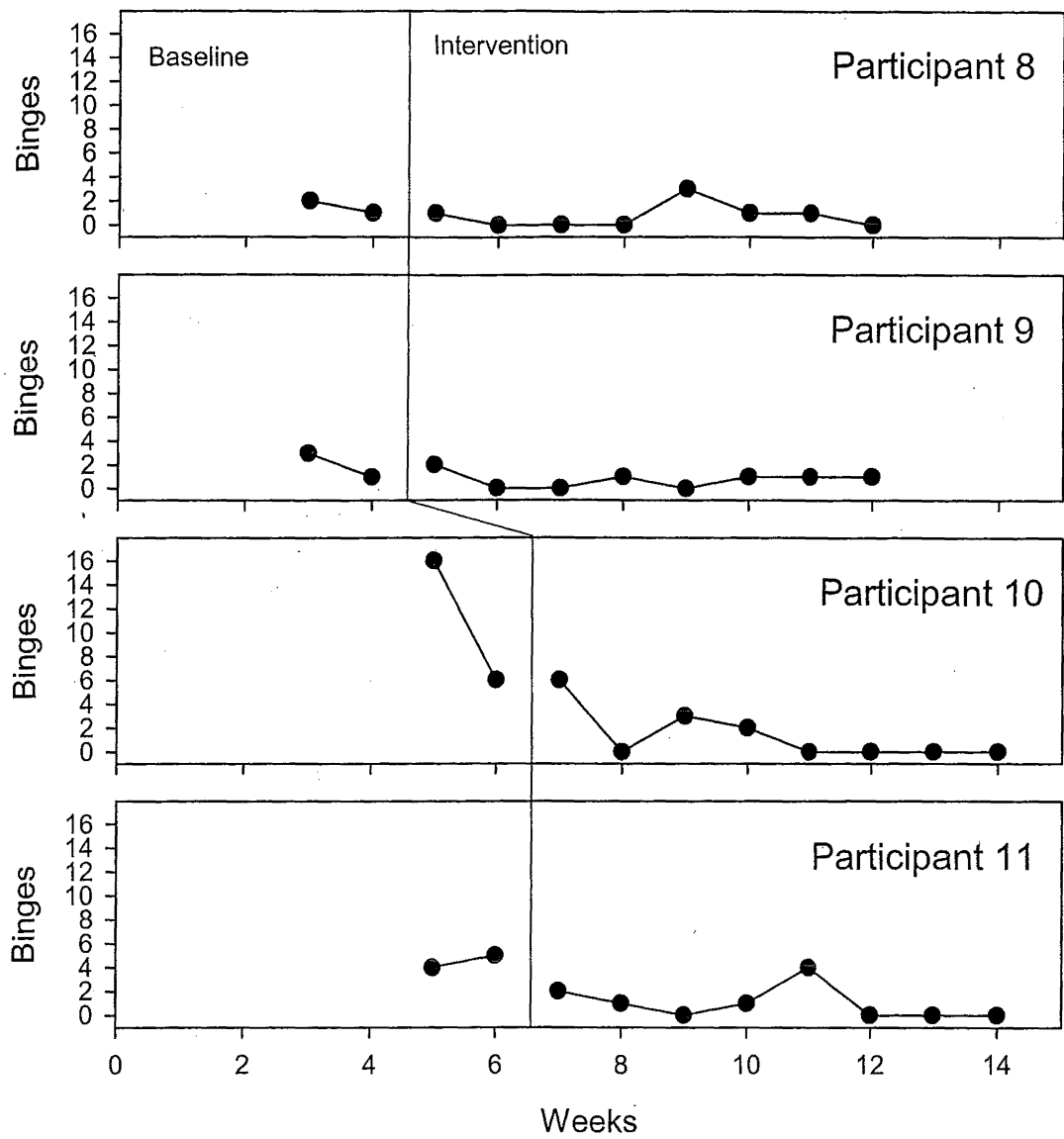
The multiple baseline graphs below (Figure 4) illustrate the decreasing trend evident in each participant.

Figure 4: Multiple Baseline Graph of the Weekly Binge Frequencies for Each Participant.



Continued over ...

Figure 4: Multiple Baseline Graph of the Weekly Binge Frequencies for Each Participant (cont).



At baseline, four of the eleven participants binged at a rate higher than seven binges per week. In the first week of baseline these ranged from 16 binges per week, to 10 binges per week. These participants all reduced in their binge frequency in the second week of baseline, which is likely to be a reaction to the act of self-monitoring. Although the remaining seven participants did not appear to binge a great deal, it should be noted that they still fitted the criteria for binge eating disorder, which requires at least two binges per week.

At intervention, of those who binged at the greatest rate at baseline, participant 1 immediately reduced to no binges in the first week of the programme. This appears to be a programme participation effect, where simply attending the treatment programme resulted in a reduction of binge frequency. The weekly binge frequency of participant 3, who also binged at the greatest rate at baseline, and participants 4 and 9, however, increased from baseline to the first week of intervention. The weekly binge frequency of participants 2, 5, 6, 7, 8, and 11 initially remained relatively the same as baseline, and then declined to a low, and finally zero, level after several weeks in the programme.

Overall, while participants 2, 3, and 10 all show a clear treatment effect from baseline to the end of the intervention, participants 7 and 11 show a less dramatically evident treatment effect. Notably, while the trend of the weekly binge frequency of participant 11 in baseline appears to be increasing, at intervention this trend reversed and weekly binge frequency decreased. Participant 1 appeared to show a programme participation effect, and participants 4 and 5 show some evidence of a treatment effect, although this was compromised by the floor effect apparent in baseline.

QUESTIONNAIRE RESULTS

At baseline, all participants fitted the criteria for binge eating disorder according to the QEWP. At post-intervention, only one participant in Group One continued to fit the

criteria for binge eating disorder after the programme had been administered. At follow-up, no participant fitted the criteria for binge eating disorder on the QEWP.

Two repeated measures multivariate analyses of variance (MANOVAs) statistical tests were performed, each comparing group means on nine measures. The first MANOVA compared mean scores at pre-treatment and post-treatment, where the second MANOVA compared post-treatment and follow-up means¹. The measures compared were the BES, the DASS including depression, anxiety and stress as separate measures, the PSS, the EI, the TAS, and adaptive and maladaptive coping styles from the COPE. In order that they could be meaningfully compared, the variables on the COPE were grouped as “Adaptive” coping and “Maladaptive” coping in accordance with Carver and associates (1989) and Johnson and associates (1995). Adaptive coping included active coping, planning, seeking instrumental social support, positive reinterpretation and growth, acceptance, seeking emotional social support, suppression of competing activities, and restraint coping (Carver et al., 1989). Maladaptive coping included focusing on and venting of emotions, denial, mental and behavioural disengagement, and alcohol and/or drug use (Carver et al., 1989). A full summary of the descriptive statistics for pre-treatment compared to post-treatment, and post-treatment compared to follow-up, for the BES, the DASS, the PSS, the EI, the TAS, and the COPE can be viewed in Appendix 8. Graphs of the means across groups for each measure can be viewed in Figures 5, 6, 7, 8, 9, and 10, on pages 65, 66, and 67.

The results of the pre to post repeated measures MANOVA revealed a main effect for measure [$F(7,70) = 160.19, p < 0.01$], a main effect for time [$F(1,10) = 7.6, p < 0.05$], and an interaction effect between measure and time [$F(7,70) = 7.61, p < 0.01$]. As a significant interaction effect was found between measure and time, planned comparison univariate tests were performed on all nine measures.

¹ The MANOVAs were split in this way because of loss of two cases from follow-up. A single MANOVA over three time periods would have led to loss of all data from these two cases.

On the BES, the pre-intervention mean was 30 (SD = 7.07) but had reduced post-intervention to 11.18 (SD = 5.05) [$F(1,10) = 56.65$, $p < 0.01$]. The mean for depression pre-intervention was 17.9 (SD = 15.53) but had decreased to 10.81 (SD = 12.25) post-intervention [$F(1,10) = 16.92$, $p < 0.01$]. The mean on the PSS pre-intervention was 31.45 (SD = 9.11) which reduced to 26 (SD = 7.84) post-intervention [$F(1,10) = 11.26$, $p < 0.01$]. The mean on the TAS pre-intervention was 60.9 (SD = 12.3) but had decreased to 52.82 (SD = 11.36) post-intervention [$F(1,10) = 8.62$, $p < 0.05$].

The DASS mean for anxiety pre-intervention was 10.36 (SD = 11.46) and had not changed post-intervention ($m = 7.27$, SD = 8.7) [$F(1,10) = 1.54$, ns], while the mean for stress pre-intervention was 20.73 (SD = 14.67) and also did not change post-intervention ($m = 16.36$, SD = 13.94) [$F(1,10) = 1.97$, ns]. The mean for emotional intelligence on the EI pre-intervention was 113.36 (SD = 19.52) and had not changed post-intervention. The mean post-intervention on the EI increased to 122.45 (SD = 12.44) [$F(1,10) = 3$, $p = 0.11$], a non-significant increase may have been due to the small sample size. Effect size for the EI pre-treatment compared to post-treatment was medium (0.47) and not large. The mean score for adaptive coping strategies on the COPE was 34.97 (SD = 12.57) pre-intervention and had not changed post-intervention. The mean adaptive coping score for post-intervention was 40.33 (SD = 16.55) [$F(1,10) = 3.67$, $p = \text{ns}$]. The mean for maladaptive coping score on the COPE pre-intervention was 30.67 (SD = 12.71) and 29.2 (SD = 12.66) post-intervention [$F(1,10) = 1.05$, $p = \text{ns}$].

The results of the repeated measures MANOVA for post to follow-up revealed a main effect for measure [$F(8,64) = 123.26$, $p < 0.01$], and a main effect for time [$F(1,8) = 6.01$, $p < 0.05$]. However, there was no interaction effect between measure and time [$F(8,64) < 1$, ns]. To determine whether any changes occurred on any of the measures from post to follow-up, planned comparison univariate tests were performed on all nine measures.

The mean for alexithymia measured on the TAS reduced from post to follow-up (mean = 49.33, SD = 11.34) [$F(1,8) = 5.81$, $p < 0.05$]. In addition, the mean maladaptive coping

strategies score measured on the COPE decreased from post to follow-up (mean = 21.13, SD = 9.97) [$F(1,8) = 12.86$, $p < 0.01$].

On the BES, there was no change between the mean at post and follow-up (mean = 12.33, SD = 7.71) [$F(1,8) < 1$, ns]. The mean for depression on the DASS at post-treatment showed no change at follow-up (mean = 7.22, SD = 5.99) [$F(1,8) = 1.96$, ns], and the mean for anxiety did not change at follow-up (mean = 5.22, SD = 5.29) [$F(1,8) = 1.90$, ns]. The mean for the stress measure on the DASS had not changed from post to follow-up (mean = 13.11, SD = 8.04) [$F(1,8) = 1.07$, ns]. The mean for perceived stress on the PSS had not changed from post to follow-up (mean = 26.78, SD = 9.2) [$F(1,8) < 1$, ns]. The mean for emotional intelligence measured on the EI had not changed from post to follow-up (mean = 117.67, SD = 16.86) [$F(1,8) < 1$, ns]. The mean on adaptive coping strategies measured on the COPE did not change from post to follow-up (mean = 30.58; SD = 16.21) [$F(1,8) = 1.19$, ns].

Graphs of Means Across Groups for All Questionnaires: Pre- and Post-intervention, and Follow-up

Figure 5: The Binge Eating Scale; Means for Pre- and Post-intervention, and Follow-up

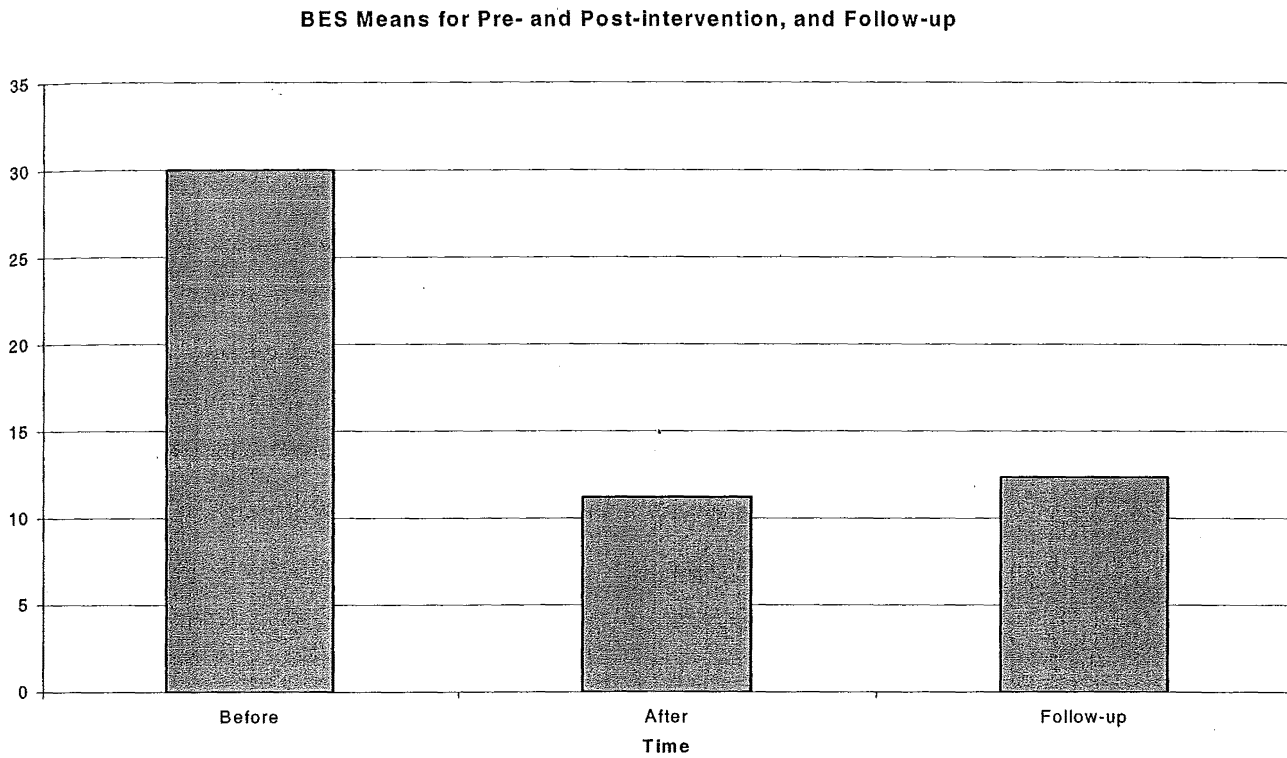


Figure 6: The Depression-Anxiety-Stress Scales; Means for Pre- and Post-intervention, and Follow-up

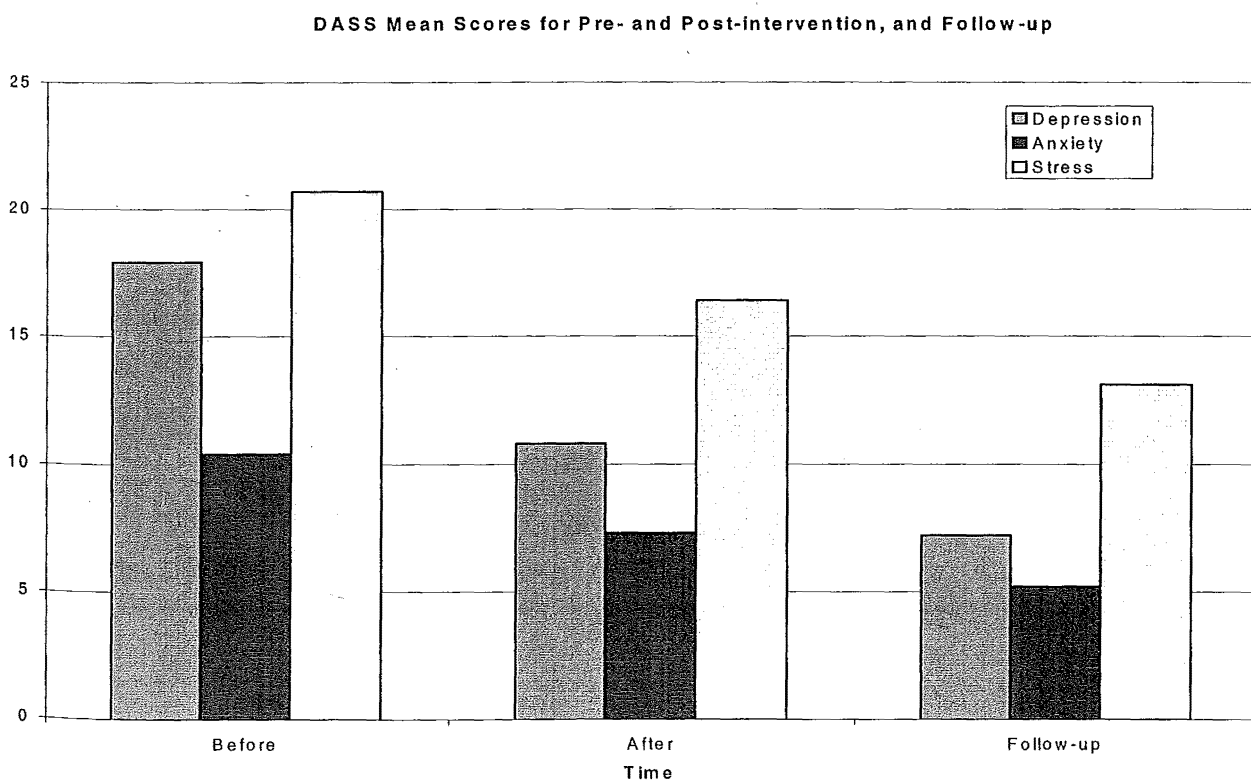


Figure 7: The Perceived Stress Scale; Means for Pre- and Post-intervention, and Follow-up

PSS Mean Scores for Pre- and Post-intervention, and Follow-up

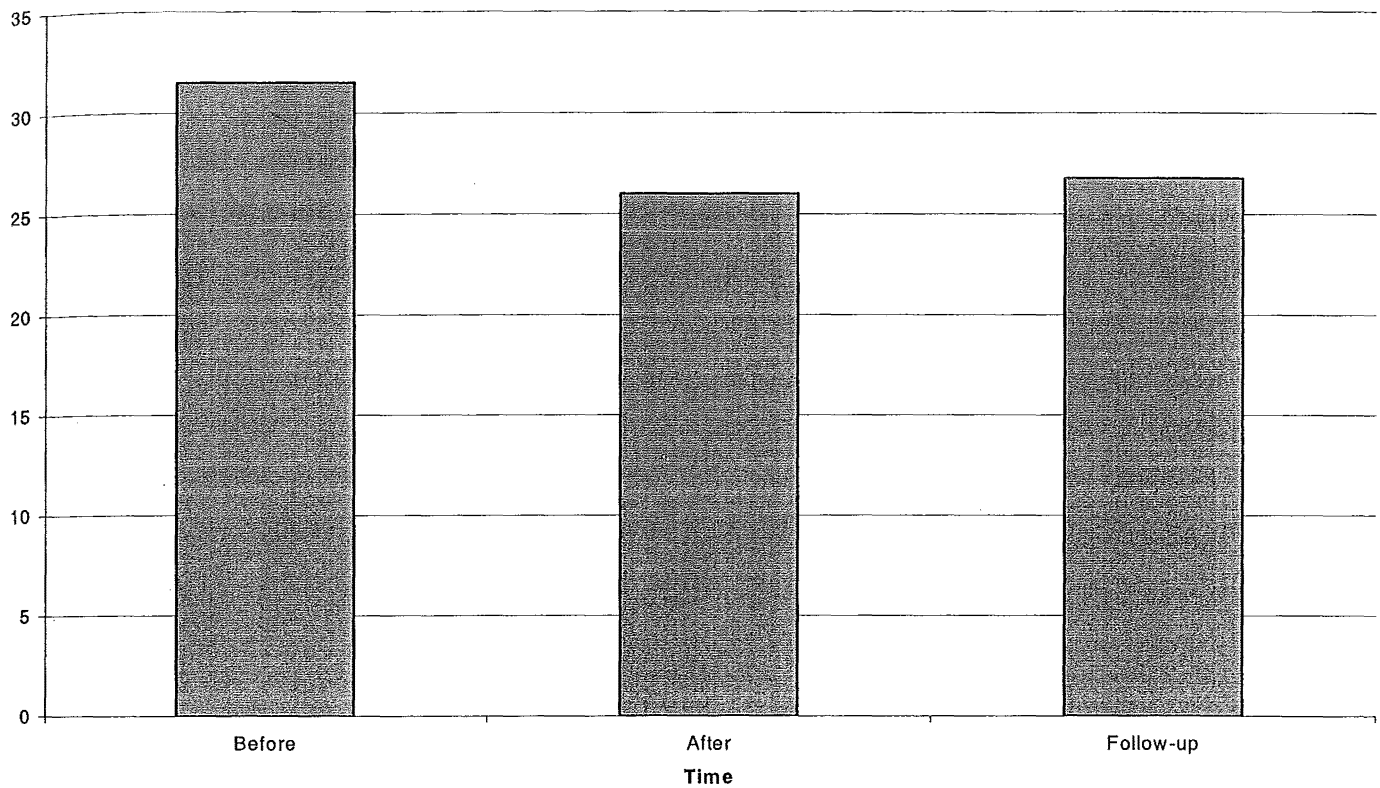


Figure 8: The Emotional Intelligence Scale: Means for Pre- and Post-intervention, and Follow-up

EI Mean Scores for Pre- and Post-intervention, and Follow-up

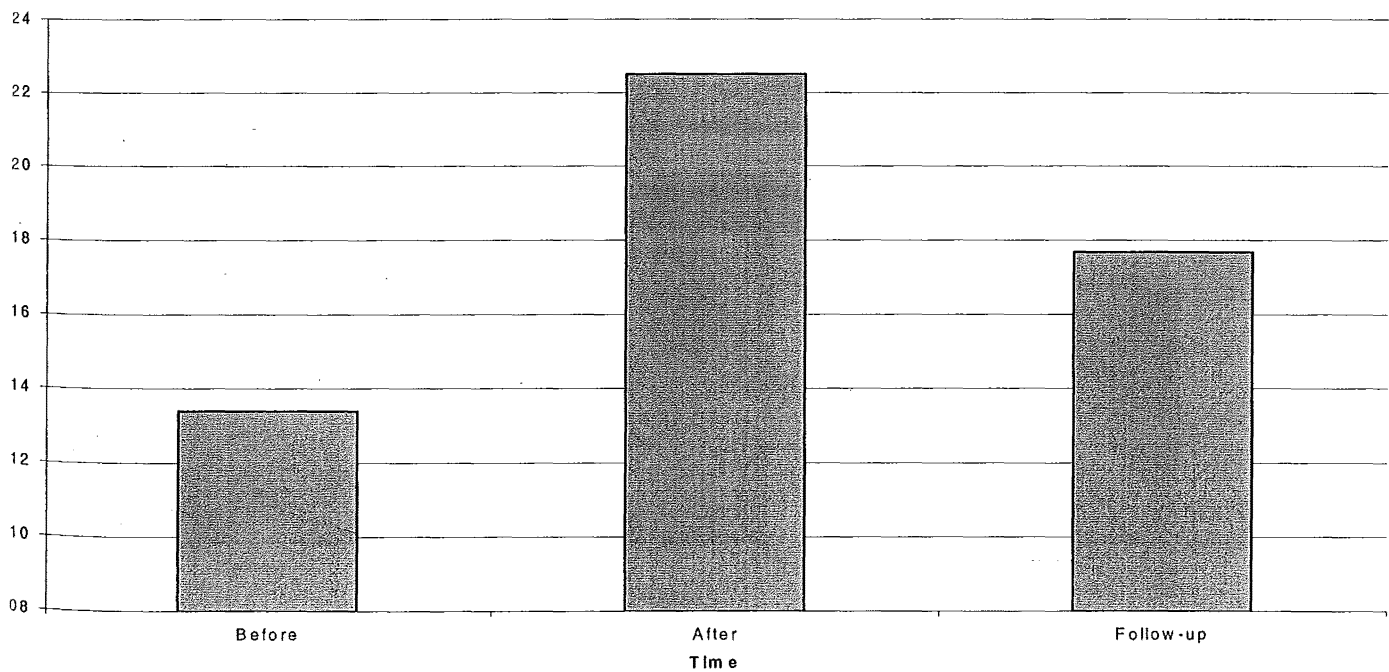


Figure 9: The Toronto Alexithymia Scale; Means for Pre- and Post-intervention, and Follow-up

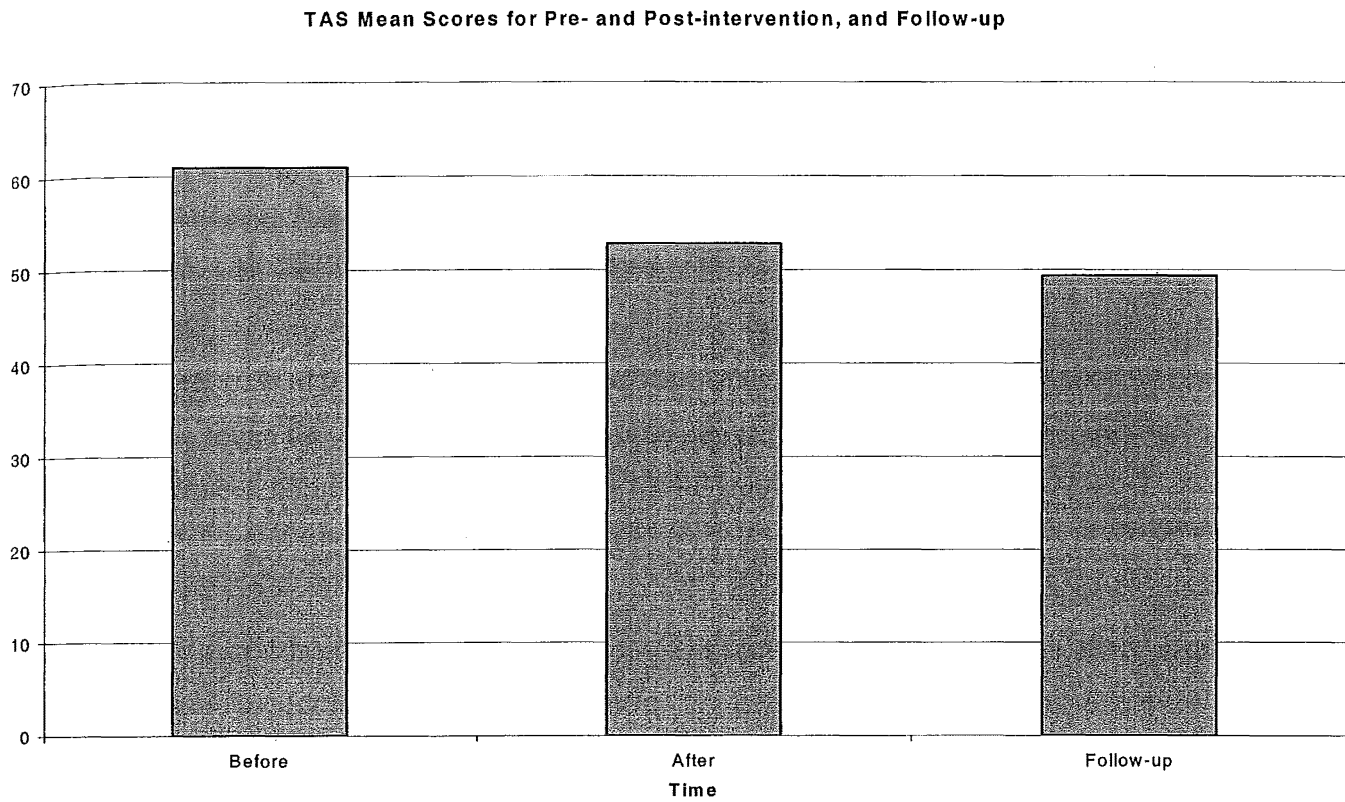
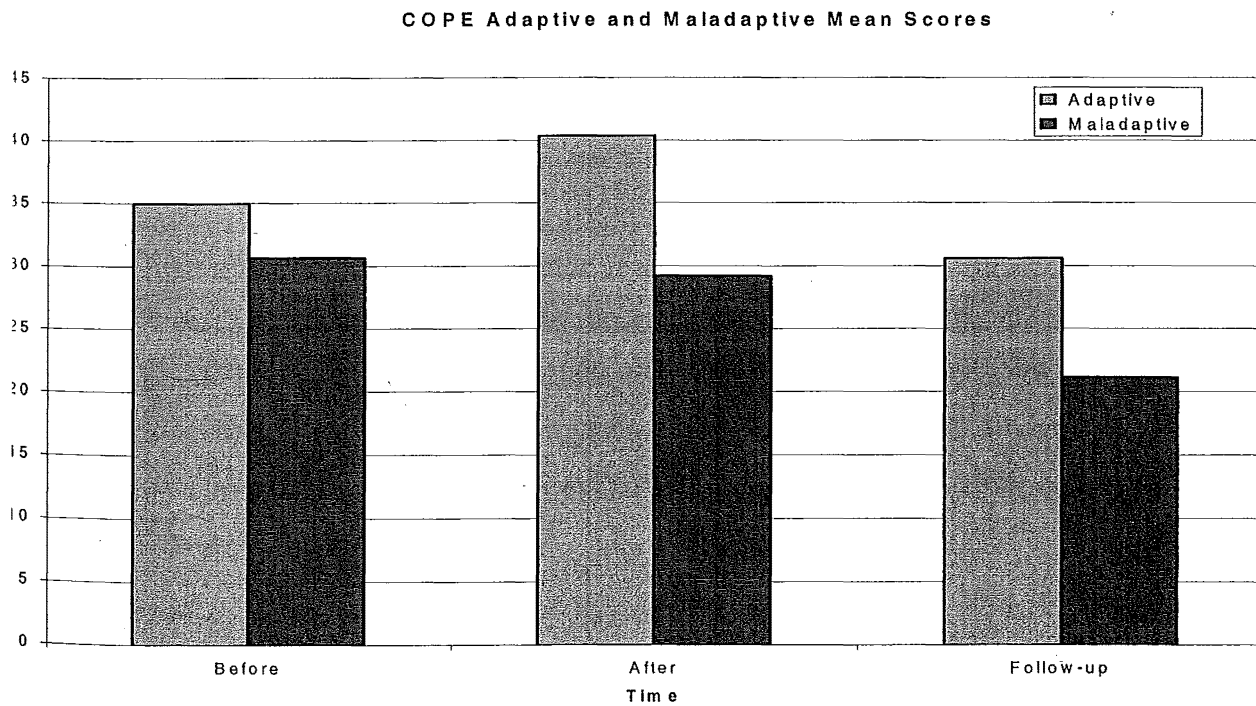


Figure 10: The COPE; Means for Pre- and Post-intervention, and Follow-up



Effect Sizes

A full summary of the effect sizes for pre-treatment compared to post-treatment, and post-treatment compared to follow-up can be viewed in Appendix 8. Effect sizes of 0.8 or higher were classified as large, according to the suggestions of Cohen (1988). A large effect size was only found for the BES from pre-treatment to post-treatment.

Effect sizes of 0.5 to 0.79 were classified as medium (Cohen, 1988). Medium effect sizes were found for the PSS from pre to post-treatment, for the TAS from pre to post-treatment, for adaptive coping from the COPE from post to follow-up, and for maladaptive coping from the COPE for post to follow-up.

Effect sizes from 0.2 to 0.49 were classified as small (Cohen, 1988). Small effect sizes were found for BES from post to follow-up, for depression from pre to post-treatment and from post to follow-up, for anxiety from pre to post-treatment and from post to follow-up, for stress from pre to post-treatment and from post to follow-up, for the PSS from post to follow-up, for the EI from pre to post-treatment and from post to follow-up, for the TAS from post to follow-up, for adaptive from pre to post-treatment and for maladaptive coping from pre to post-treatment.

Correlations Between Psychometric Tests

Pearson-product moment correlation co-efficients were calculated for all nine measures in baseline, including the BES, depression, anxiety, and stress on the DASS, the PSS, the EI, the TAS, and adaptive and maladaptive coping scores from the COPE. Because of the small sample size, only large correlations were significant ($p=0.05$ or better). Only these correlations significant at $p<0.05$ and points of particular interest are reported (see Table 2, page 69).

Table 2: Summary of the Pearson-product Moment Correlation Co-efficients Calculated for the BES, the DASS, the PSS, the EI, the TAS, and the COPE. (The significance levels of the correlations are in brackets.)

	<i>BES</i>	<i>Dep</i>	<i>Anx</i>	<i>Stress</i>	<i>PSS</i>	<i>EI</i>	<i>TAS</i>	<i>Adap</i>	<i>Maladap</i>
<i>BES</i>	1	0.75 (0.001)	0.62 (0.042)	0.75 (0.001)	0.63 (0.004)	-0.54 (0.09)	0.82 (0.002)	-0.02 (0.96)	0.76 (0.007)
<i>Dep</i>	0.75 (0.001)	1	0.79 (0.004)	0.78 (0.004)	0.9 (0.001)	-0.55 (0.08)	0.72 (0.012)	0.07 (0.83)	0.86 (0.001)
<i>Anx</i>	0.62 (0.042)	0.79 (0.004)	1	0.45 (0.165)	0.76 (0.007)	-0.51 (0.111)	0.8 (0.003)	-0.15 (0.665)	0.7 (0.017)
<i>Stress</i>	0.75 (0.001)	0.78 (0.004)	0.45 (0.165)	1	0.72 (0.012)	-0.48 (0.133)	0.62 (0.043)	0.25 (0.467)	0.71 (0.015)
<i>PSS</i>	0.63 (0.004)	0.9 (0.001)	0.76 (0.007)	0.72 (0.012)	1	-0.47 (0.149)	0.78 (0.005)	-0.11 (0.757)	0.72 (0.013)
<i>EI</i>	-0.54 (0.09)	-0.55 (0.08)	-0.51 (0.111)	-0.48 (0.133)	-0.47 (0.149)	1	-0.63 (0.04)	0.29 (0.386)	-0.55 (0.08)
<i>TAS</i>	0.82 (0.002)	0.72 (0.012)	0.8 (0.003)	0.62 (0.043)	0.78 (0.005)	-0.63 (0.04)	1	-0.31 (0.631)	0.66 (0.026)
<i>Adap</i>	-0.02 (0.96)	0.07 (0.83)	-0.15 (0.665)	0.25 (0.467)	-0.11 (0.757)	0.29 (0.386)	-0.31 (0.631)	1	0.3 (0.37)
<i>Maladap</i>	0.76 (0.007)	0.86 (0.001)	0.7 (0.017)	0.71 (0.015)	0.72 (0.013)	-0.55 (0.08)	0.66 (0.026)	0.3 (0.37)	1

Relationships were revealed between the BES and depression from the DASS ($r = 0.75$), the BES and anxiety from the DASS ($r = 0.62$), the BES and stress from the DASS ($r = 0.75$), the BES and the PSS ($r = 0.63$), indicating a relationship between mood, stress, and binge eating. Relationships were also revealed between the BES and TAS ($r = 0.82$), and the BES and maladaptive coping from the COPE ($r = 0.76$), suggesting a relationship between alexithymia and binge eating problems, and maladaptive coping and binge eating problems.

Relationships were revealed between the depression and anxiety from the DASS ($r = 0.79$), between depression and stress from the DASS ($r = 0.78$), between depression and the PSS ($r = 0.9$), between depression and the TAS ($r = 0.72$), and between depression and maladaptive coping from the COPE ($r = 0.86$). This suggests a relationship between

depression and anxiety, between depression and stress and perceived stress, and depression and maladaptive coping.

Relationships were revealed between anxiety and the PSS ($r = 0.76$), the TAS ($r = 0.8$), and maladaptive coping ($r = 0.7$). Relationships were revealed between stress and the PSS ($r = 0.72$), indicating that both tests measure the same construct. Relationships were revealed between stress on the DASS and the TAS ($r = 0.62$), between the PSS and the TAS ($r = 0.78$), between stress and maladaptive coping from the COPE ($r = 0.71$), and also between the PSS and maladaptive coping ($r = 0.72$). This indicates that stress and perceived stress are both related to alexithymia and maladaptive coping.

Relationships were also found between the TAS and maladaptive coping ($r = 0.66$), suggesting a relationship between alexithymia and maladaptive coping. A negative relationship was revealed between the EI and the TAS ($r = -0.63$), which indicates a negative relationship between alexithymia and emotional intelligence.

In addition, a large negative correlation was found between BES and EI, but this was not significant ($r = -0.54$). It is likely that with a larger sample size, the correlation between the EI and the BES would obtain significance.

Interestingly, only a small, non-significant relationship was found between anxiety and stress ($r = 0.45$). It should also be noted that a low but positive non-significant relationship was revealed between adaptive and maladaptive coping ($r = 0.3$). This may represent an artifact of response styles for answering this questionnaire. Those participants who reported using many adaptive coping strategies also tended to report using many maladaptive coping strategies, and vice versa.

ACTIVATED THOUGHTS AND SIMULATED SITUATIONS RESULTS

The ATSS involved presenting the participants with a tape of three neutral scenarios, ten emotion-evoking scenarios, and ended with two neutral scenarios. As was described in full in the method section, neutral scenarios were not expected to produce strong emotional reactions. A typical response to the scenario concerning breakfast was *“well, then I would either go over and get some, or I would have something else”*. After the second part of the scenario was presented, a typical response was *“that sounds lovely.”* Unlike the neutral scenarios, the emotion-evoking scenarios were expected to evoke emotional responses. There were many varied responses to the emotion-evoking statements. For example, the responses to the second part of the scenario concerning theft at work varied considerably, e.g., *“I would tell the boss who took the piece of stationery”*, *“I would set up a three way meeting between myself, the boss, and the person who took the item”*, and *“I would approach the person who took it and tell them that I saw them take the item”*.

The participants' responses were coded as “idea units” and categorised in accordance to the classifications outlined by Davison and associates (1983). Statements the participants made that fitted more than one idea unit were categorised more than once. Examples of statements the participants made that were categorised as more than one idea unit are *“that would be nice, but I would be afraid something would happen”*, or *“I would either act non-assertively and put up with the situation, or I might act assertively, depending on my mood during that day.”* The first statement would count one point to both positive anticipation and negative anticipation, thus scoring one point in two different idea units. The second statement would count one to both non-assertive and assertive responses. The example statements were categorised as positive feeling and negative anticipation, and non-assertive response and assertive response respectively.

The categories modeled on Davison and associates (1983) were aggregated to make the analysis less complicated [Davison and associates (1983) terms and definitions of terms can be viewed in Appendix 9]. The groups of categories were positive feeling, (which

included positive evaluation of the self, positive evaluation of the referent, positive evaluation of the speaker, and positive evaluation of other, positive anticipation, and positive feeling), negative feeling (which included critical evaluation of the speaker, critical evaluation of the referent, critical evaluation of other, negative anticipation, and negative feeling), problem solving (as described by Davison et al., 1983), neutral statements (describe the self, other, and should) and negative self-statement (which was critical evaluation of the self).¹ Describe the self statements were considered neutral statements as they did not provide any useful information. Describe the self statements included responses such as “I wouldn’t do that, I would do this”, or “yes, that sounds like me”.

The frequency of different categories of articulated thoughts in response to the neutral and emotion-evoking scenarios, at baseline and post-intervention, were totalled over all participants, and are shown in Table 3. The ATSS data was analysed using descriptive statistics, and the mean number of responses over all participants for each idea unit, neutral and emotion-evoking at baseline and post-intervention are shown in Table 4. (For a full summary of the descriptive statistics for the ATSS data, see Appendix 8). The graphs of the ATSS totals and means for each different idea unit are shown in Figures 11 and 12.

¹ Davison and associates (1983) idea units that were not included were *agree with the speaker*, *desire to harm*, *defense of the self*, *defense of the referent*, *defense of the speaker*, *defense of other*, and *empathy with the speaker*. These were not included as the participants did not respond with these types of statements at any time.

Table 3: Frequency of Different Idea Units Totalled Over all Participants.

	<i>Pre-intervention</i>		<i>Post-intervention</i>	
	Neutral	Emotion-evoking	Neutral	Emotion-evoking
Positive Feeling	64	56	68	72
Negative Feeling	16	123	6	61
Negative Self-statement	0	26	0	7
Neutral Statement	42	82	33	64
Problem Solving	24	113	34	125

Table 4: Mean Frequency of Different Idea Units Over all Participants.

	<i>Pre-intervention</i>		<i>Post-intervention</i>	
	Neutral	Emotion-evoking	Neutral	Emotion-evoking
Problem Solving	1.6	2.51	1.89	2.36
Positive Feeling	4.92	4	3.78	3.27
Negative Feeling	1.6	6.83	1.5	3.21
Negative Self-statement	1	3.25	0	1.4
Neutral Statement	2.62	3.9	2.06	3.37

Figure 11: Frequency of Different Idea Units Totalled Over all Participants

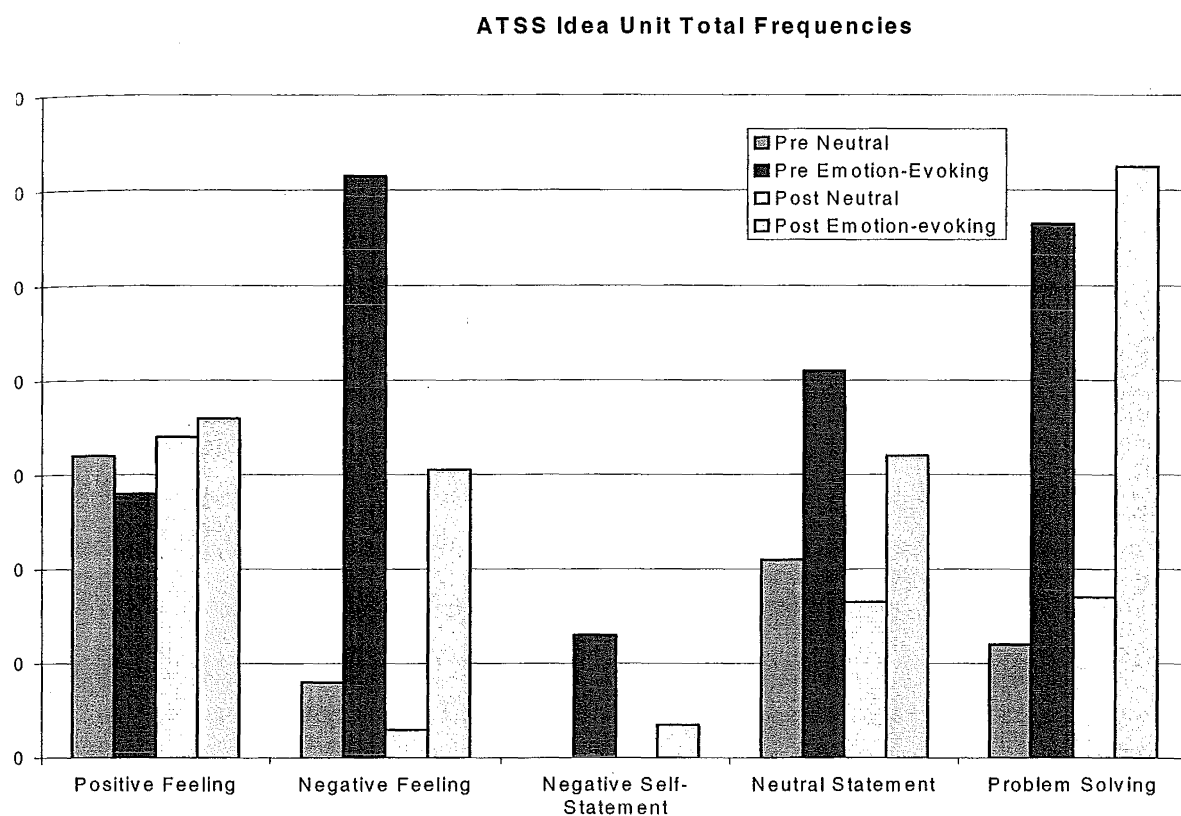
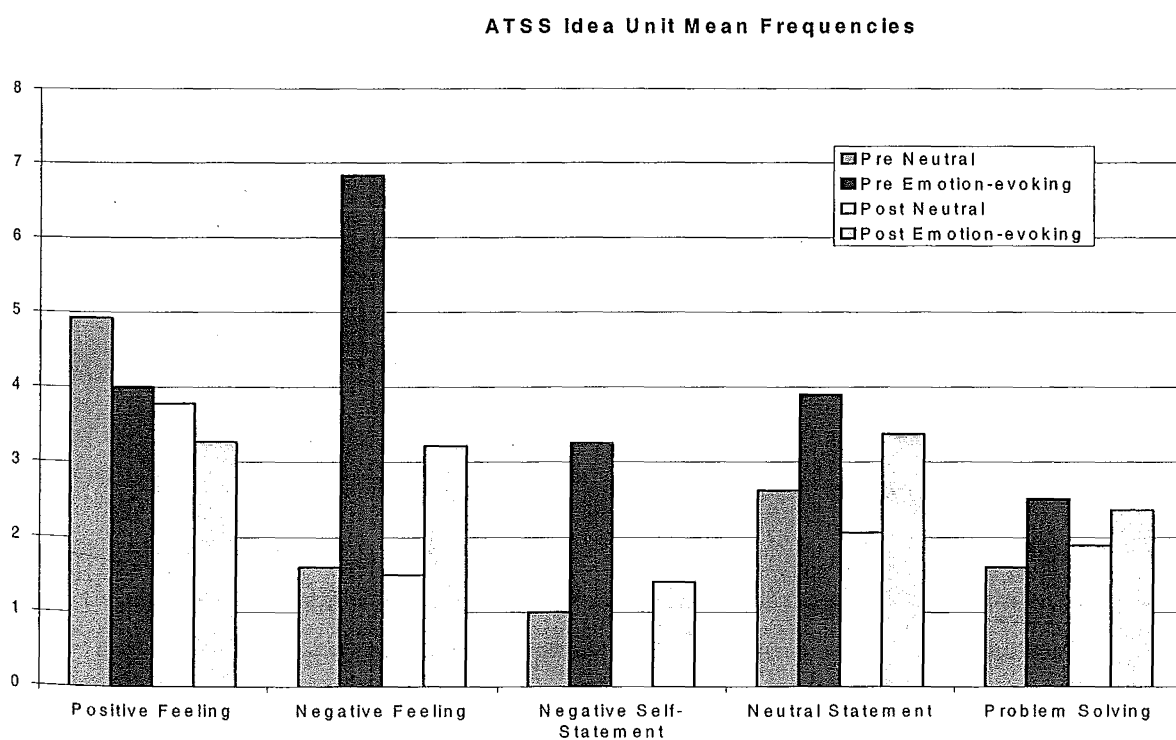


Figure 12: Mean Frequency of Different Idea Units Over all Participants



Where “Pre Neutral” means pre-intervention, neutral scenario scores; “Pre Emotion-evoking” means pre-intervention, emotion-evoking scenario scores; “Post Neutral” means post-intervention, neutral scenario scores, and “Post Emotion-evoking” means post-intervention, emotion-evoking scenarios.

A typical positive feeling statement in response to both the neutral and emotion-evoking scenarios was “*that would be lovely*”, or words to that effect. The neutral scenarios evoked a total of 64 positive feeling statements at baseline, and 68 following intervention. The participants made from three to nine positive feeling statements in baseline, and from four to ten statements post-treatment. These scores were representative of all the participants and neither the lowest score nor the highest score in the neutral scenarios for pre- to post-intervention were extreme. The mean positive feeling responses were 4.92 pre- and 3.78 post-intervention. Although there appears that there was a reduction in the positive feeling statements from pre- to post-intervention in response to the neutral scenarios, the total scores do not differ greatly. Thus, there were similar positive feeling responses recorded in response to neutral scenarios in both pre- and post-intervention.

The emotion-evoking scenarios evoked a total of 56 positive feeling statements pre- and 72 post-intervention. The participants made from three to seven positive feeling responses to the emotion-evoking scenarios pre-intervention, and from two to eleven responses post-intervention. The mean positive feeling statements in response to the emotion-evoking scenarios were 4 pre- and 3.27 post-intervention. Although there seems to be a reduction in positive feeling responses from baseline to post-intervention, the mean values do not represent the variance in responses recorded. Out of a total of the eleven participants, only two responded with less positive feeling statements in response to emotion-evoking scenarios from pre- to post-intervention. Specifically, one participant responded with one less positive feeling statement from pre- to post-intervention, and the other responded with only two less positive feeling statements to the emotion-evoking scenarios from pre- to post-intervention. The second participant only responded with four positive feeling statements in response to the emotion-evoking scenarios pre-intervention

and two post-intervention. It can be concluded that there was not much change in positive feeling response in the emotion-evoking scenarios from baseline to post-intervention. If any change was to be noted, the majority of the participants responded with slightly more positive feeling statements after the programme was administered.

The neutral scenarios evoked a total of 16 negative feeling statements pre- and 6 statements post-intervention. The participants made from zero to four negative feeling statements in response to the neutral scenarios in baseline, and from zero to two post-intervention. The negative feeling statements in response to the neutral scenarios pre-intervention were often statements referring to eating too much bread after getting some for breakfast. However, this was not the case for the negative feeling statements recorded in response to the neutral scenarios post-intervention. Very few participants actually responded negatively to the neutral scenarios after the programme. The only participant who did respond negatively, responded twice and referred to feeling nervous before a job interview and feeling angry about waiting at the petrol station to be served. The means negative feeling statements in response to the neutral scenarios were 1.6 at baseline and 1.5 post-intervention. It could be argued that no change has occurred in the frequency of negative feeling statements in response to neutral scenarios from baseline to post-intervention. However, when the drop from the total negative responses from baseline to post-intervention is taken into account, it is clear that the participants responded negatively to the neutral scenarios less after the programme than they did before the programme. Moreover, in regards to the neutral scenarios, no participant responded more negatively after the Programme. Thus, all participants responded either equally or less negatively after the programme.

The total emotion-evoking scenarios evoked 123 negative feeling statements pre- and 61 post-intervention. The mean negative feeling statements in response to the emotion-evoking scenarios reduced from 6.83 to 3.21. Clearly, these results show that the participants responded much less negatively to the emotion-evoking scenarios after the programme was administered.

No negative self-statements were recorded in response to the neutral scenarios at baseline and post-intervention. This was entirely anticipated, as one would not expect a critical statement about the self in response to neutral scenarios. The emotion-evoking scenarios evoked 26 negative self-statements at baseline, and 7 post-intervention. The emotion-evoking scenarios evoked a mean of 3.25 negative self-statements at baseline. This reduced to a mean of 1.4 negative self-statements at post-intervention. Thus, the participants made far less negative self statements after the programme than they did before. The majority of the negative self statements for the emotion-evoking scenarios at baseline and post-intervention were in reference to how much they disliked their body image.

The neutral scenarios evoked a total of 42 neutral statements at baseline and 33 post-intervention. The mean for the neutral statements recorded at baseline in response to the neutral scenarios was 2.62 and 2.06 post-intervention. The majority of the neutral statements made in response to the neutral scenarios pre- and post-intervention were describe-the-self statements. The emotion-evoking scenarios evoked a mean of 3.9 neutral statements at baseline which reduced to 3.37 post-intervention. This appeared to be due to the reduction in describe-the-self statements from pre- to post-intervention in response to the emotion-evoking scenarios. These reduced from a total of 64 describe-the-self statements across groups pre-intervention (or a mean of 5.81 per participant) to a total of 49 across groups (or a mean of 4.45) after the programme.

The neutral scenarios produced a total of 24 problem solving statements at baseline and 34 post-intervention. The participants made from zero to seven problem solving statements in response to the neutral scenarios at baseline, and from zero to seven post-intervention. The participant who made seven problem solving statements in response to the neutral scenarios made six active coping statements at baseline and five active coping responses post-intervention. For instance, to the neutral scenario mentioned above, she responded to the effect of *"I would find a shop and buy some bread"* before she was told the rest of the scenario. The mean problem solving statements in response to the neutral

scenarios were 1.6 at baseline and 1.89 post-intervention. These means would have been slightly skewed by the seven problem solving statements recorded by the one participant.

The emotion-evoking scenarios evoked a total of 113 problem solving responses at baseline and 125 post-intervention. The participants made from 1 to 16 problem solving statements in baseline and from 6 to 18 post-intervention. Although the same participant scored the highest values in this category, her frequency scores were representative of many others. The emotion-evoking scenarios produced a mean of 2.51 problem solving responses at baseline and 2.36 post-intervention.

The data was also categorised using the same categories as the COPE for adaptive and maladaptive coping strategies (Carver et al., 1989; Johnson et al., 1995). This involved categorising the problem solving statements as adaptive and maladaptive coping styles. This was done because “problem solving” can encompass both adaptive and maladaptive coping responses. For instance, while leaving the job in the emotion-evoking scenario described above is a type of problem solving in that it is an attempt to solve the situation, it is considered a maladaptive coping response as it does not deal directly with the problem in an adaptive manner. In addition, some categories were added that reflected particular components of the programme. These were assertive response (defined as a statement that indicates the person is reacting in an assertive manner to gain positive results to the situation) and non-assertive responses (defined as a statement that is not assertive, but yields to someone else’s preferences while discounting the person’s own rights and needs), stress response (defined as a statement that indicates the person responding to the situation is reacting in a stressed or anxious way to the situation) and use of relaxation (defined as a statement that indicates the person speaking is relaxed, or uses relaxation to guide their response to the situation). The assertive response and use of relaxation were considered adaptive coping responses, while the non-assertive responses and the stress responses were included as maladaptive coping responses.

The frequency of adaptive and maladaptive responses to the neutral and emotion-evoking scenarios, at baseline and post-intervention, were totalled over all participants, and are

shown in Table 5. The adaptive and maladaptive data were also analysed using descriptive statistics, and the mean number of responses over all participants, neutral and emotion-evoking pre- and post-intervention are shown in Table 6. Graphs of the adaptive and maladaptive coping response totals and mean scores are shown on Figures 13 and 14, page 80.

Table 5: Adaptive and Maladaptive Coping Response Totals for Neutral and Emotion-evoking Statements.

	Pre-intervention		Post-intervention	
	Neutral	Emotion-evoking	Neutral	Emotion-evoking
Adaptive	19	54	31	81
Maladaptive	0	55	0	35

Table 6: Adaptive and Maladaptive Coping Response Means for Neutral and Emotion-evoking Statements.

	Pre-intervention		Post-intervention	
	Neutral	Emotion-evoking	Neutral	Emotion-evoking
Adaptive	1.9	2	2.4	2.4
Maladaptive	0	3.9	0	2.9

Figure 13: Adaptive and Maladaptive Coping Response Totals for Neutral and Emotion-evoking Statements

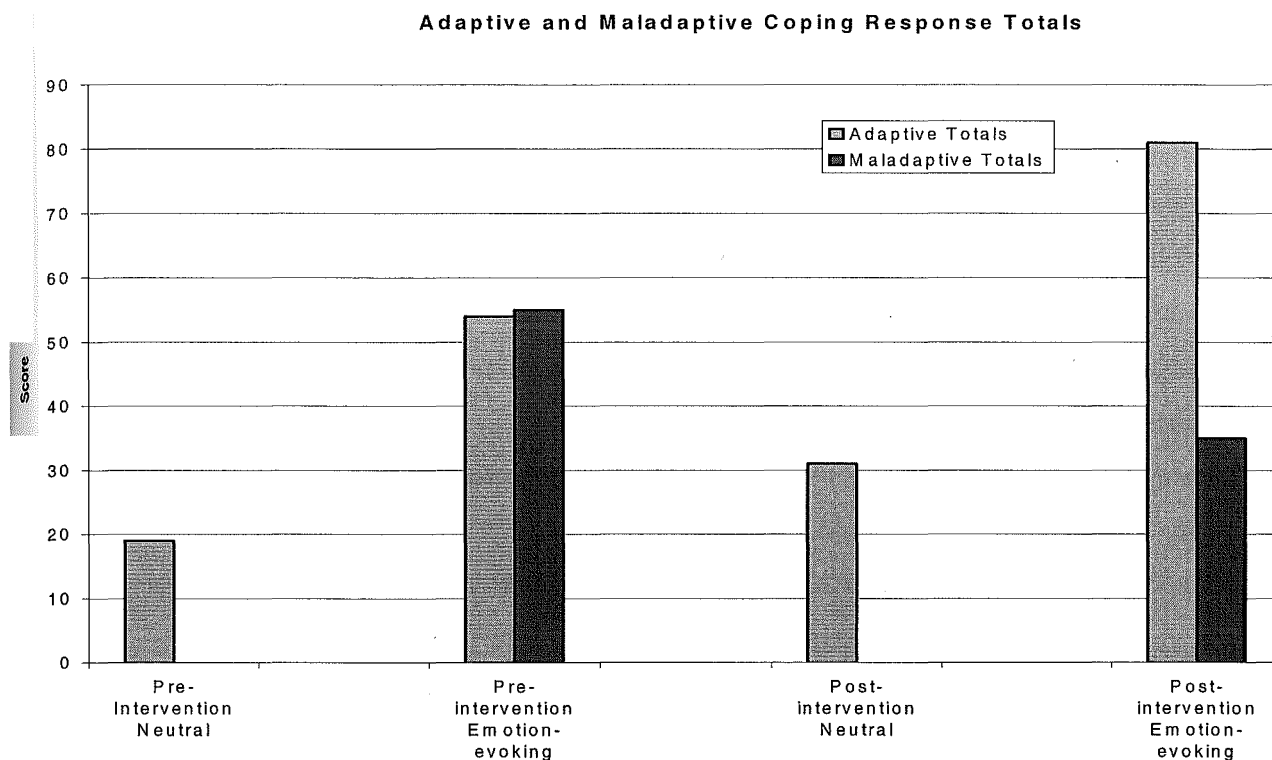
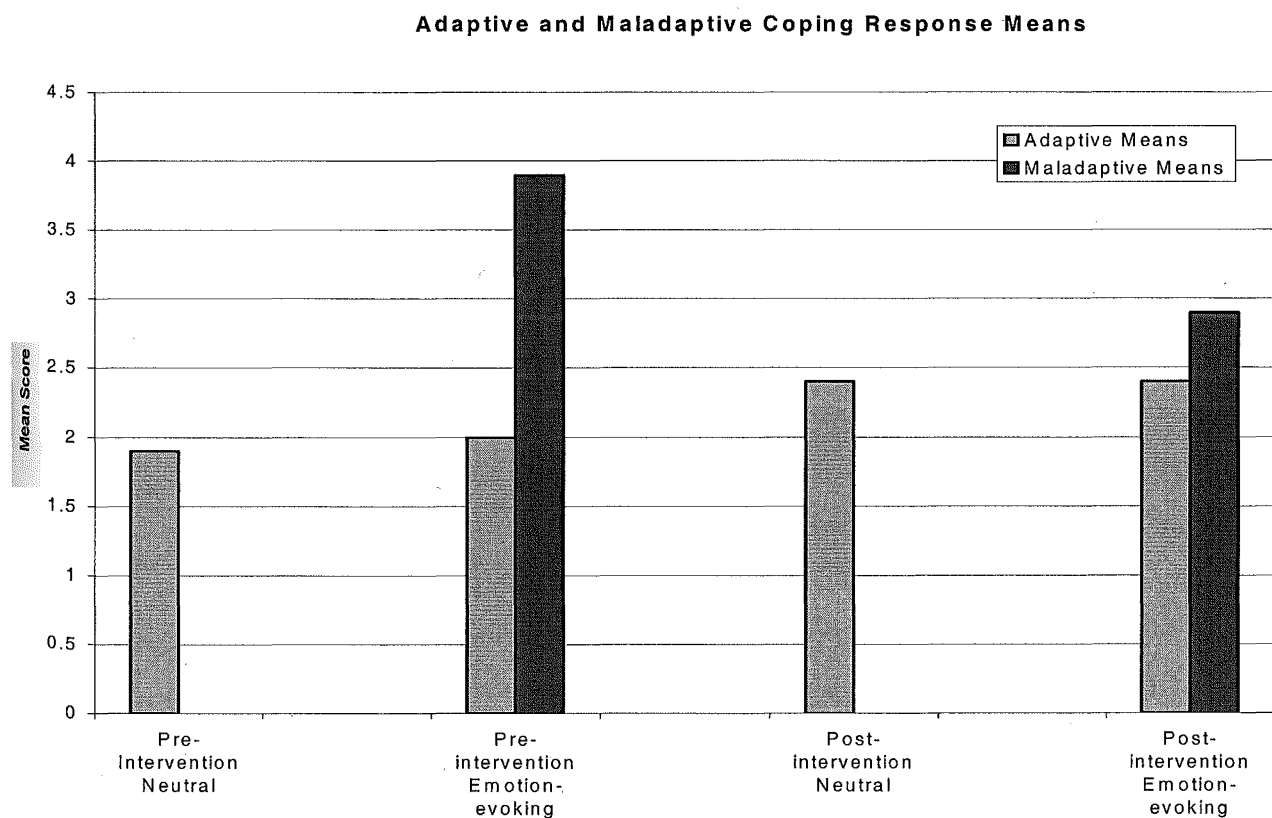


Figure 14: Adaptive and Maladaptive Coping Response Means for Neutral and Emotion-evoking Statements



The neutral scenarios evoked a total of 19 adaptive coping responses at baseline and evoked 31 post-intervention. The individual frequencies of adaptive coping statements in response to the neutral scenarios were from zero to seven at baseline and from zero to seven post-intervention. As has already been mentioned above (see the problem solving section), one participant made seven problem solving statements in response to the neutral scenarios pre- and post-intervention. In particular, she made six active coping and one seeking emotional social support responses at baseline, and five active coping and two seeking emotional social support responses post-intervention. The seeking emotional social support responses were mostly in reference to talking to friends or a partner about a hectic day. The mean adaptive coping statements for the neutral scenarios were 1.9 at baseline and 2.4 post-intervention. Although the mean scores do not indicate much of a change in the responses, the total adaptive coping statements in response to the neutral scenarios increased considerably from baseline to post-intervention.

The neutral scenarios evoked no maladaptive coping statements at baseline and post-intervention. This was anticipated as the participants were not expected to state that they would employ behavioural or mental disengagement, focus on venting of their emotions or deny the situation in neutral scenarios.

The emotion-evoking scenarios resulted in 54 adaptive coping responses at baseline and 81 post-intervention. The participants made from 2 to 11 adaptive coping statements in response emotion-evoking scenarios at baseline, and from 3 to 13 post-intervention. Although both ranges were large, the emotion-evoking scenarios produced various amounts of adaptive coping responses at baseline and post-intervention. One participant reduced from 12 adaptive coping responses at baseline to 7 from post-intervention. This may be because her statements in response to every scenario at baseline were longer than her statements in response to all scenarios post-intervention. One participant increased her adaptive coping statements in response to the emotion-evoking scenarios from 4 at baseline to 11 post-intervention, although her statements in response to the emotion-evoking scenarios did not change in length from before to after the programme. The rest of the participants increased their adaptive coping responses from one at baseline to four

extra adaptive coping statements post-intervention in response to the emotion-evoking scenarios. The mean adaptive coping statements were 2 at baseline and 2.4 post-intervention. The emotion-evoking scenarios evoked 55 maladaptive coping statements at baseline which decreased to 35 post-intervention. The mean maladaptive coping statements decreased from 3.9 at baseline to 2.9 post-intervention. Thus, both the totals and mean scores showed a decrease in the maladaptive coping statements recorded in response to the emotion-evoking scenarios from baseline to post-intervention.

SOCIAL VALIDATION MEASURES

The Programme Evaluation Questionnaire was used to determine how satisfied the participants were with the programme, and how satisfied they were with the changes they made as a result of attending the programme. The filled in Programme Evaluation Questionnaires are shown in Appendix 10.

Although the programme evaluation questionnaire used comments that could not be analysed numerically, three variables were evaluated using numerical values. Firstly, the participants were asked to indicate on a seven point Likert scale how much they enjoyed the programme, with a score of 1 indicating “not very much” and a score of 7 indicating “very much”. The mean score across participants was 6.25, indicating that the programme was highly enjoyed. The most commonly enjoyed parts of the programme were being able to relate to others, being able to recognise that they were not alone in having a binge eating problem, and being able to talk to others in a similar situation within a group setting.

Secondly, they were asked to rate on a seven point Likert scale how helpful they found the programme, with a score of 1 indicating “not very much” and a score of 7 indicating “very much”. The mean score across participants was 6.77, indicating that the programme was found to be very helpful. When asked to list which specific parts of the programme they found most helpful, the results were varied and inconsistent. However,

assertion training and problem solving were most often cited as being most helpful. Self-monitoring was cited as having been found useful by one participant, however, in the group discussion on self-monitoring during the first maintenance session the majority of the participants stated that they found it helpful in recognising their eating patterns and triggers for binge episodes.

When asked to list which specific parts of the programme they found of little use, the results were also mixed and inconsistent. One participant did not find the nutrition component useful, but this was because she had already received professional help in this area. One participant did not find the relaxation and assertion component useful as she felt she already had skills in these areas. An additional participant also stated that the assertion component was of little use, also because she considered that she already had assertion skills.

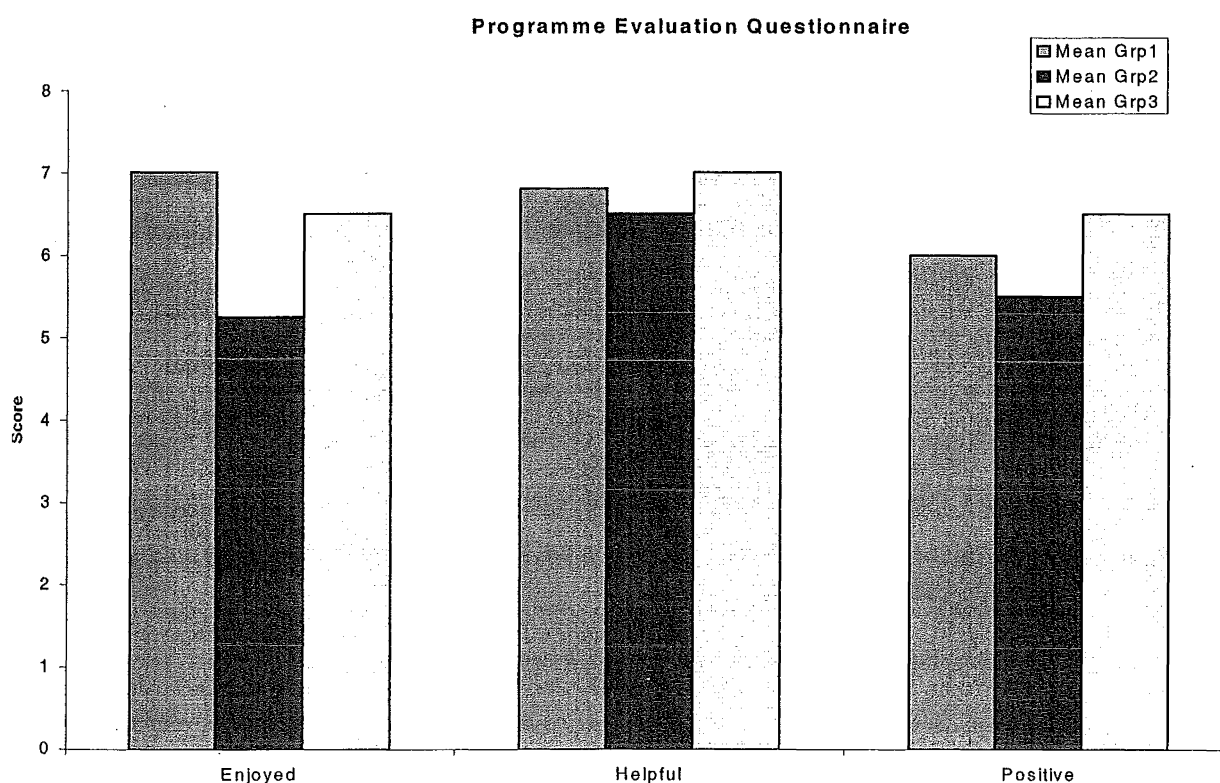
Thirdly, the participants were asked to indicate on a seven point Likert scale whether or not they felt more positive about their eating patterns particularly their binge eating, where a score of 1 indicating “not very positive” and a score of 7 indicated “very positive”. The mean score across participants was 6, indicating that the participants felt very positive about their binge eating after the programme.

Notably, when asked whether or not they would recommend the programme to a friend or family member, all participants except one answered “yes”. The participant who did not answer “yes” did not answer the question. Additionally, when asked to list any areas of the programme that may need improving, most participants did not make any suggestions. One participant suggested more feedback, and several stated that they would have preferred the programme to be longer. One participant also suggested that weekly handouts may have helped reinforce what she had learnt, and another suggested more support as an improvement.

Table 7: Mean Scores for the Programme Evaluation Questionnaire

	Enjoyed the programme	Found it helpful	Feel more positive	Recommend the programme
Group One	7	6.8	6	YES
Group Two	5.25	6.5	5.5	YES
Group Three	6.5	7	6.5	YES
Overall Mean	6.25	6.77	6	YES

Figure 15: Programme Evaluation Questionnaire Mean Scores



Key for Programme Evaluation Questionnaire Scores:

Enjoyed:	Have you enjoyed the programme?
Helpful:	Did you find the programme helpful?
Positive:	Do you feel more positive about your eating particularly your binge eating?

CHAPTER 4: DISCUSSION

Based on the results of this research, it can be tentatively concluded that teaching emotional discrimination and management is contributed to reducing binge eating problems and related symptomatology. The psychoeducational programme used in this investigation was modelled on the affect regulation theory, and included techniques similar to those employed in DBT. The programme taught self-monitoring skills, recognising binge episodes, basic nutrition, distraction techniques, the effect of emotions on binge eating problems, emotional discrimination and recognition, emotion management skills, relaxation skills, assertion training and problem solving skills. Emotional discrimination and management included physiological changes, behavioural responses, psychological aspects, and facial expressions of emotions.

The multiple baseline results revealed a decrease in the frequency of weekly binge episodes from baseline to the end of the programme. The reduction in average weekly binge frequencies was evident in all three groups, although Group Two did not show as much of a reduction as Groups One and Three. This was because the frequency of weekly binges was not as high in baseline as it was in Groups One and Three. This was unavoidable, however, as participants could not be randomly assigned to groups due to availability constraints.

The trends of the individual weekly binge frequencies were more variable than the group mean weekly binge frequencies. Overall, three participants showed a clear treatment effect, two participants showed a less dramatically clear treatment effect, and one participant showed a programme participation effect. Two participants showed some evidence of a treatment effect, but this was compromised by the floor effect apparent in baseline.

Thus, the multiple baseline design justifies certain causal assumptions. Firstly, a replication of treatment effect was evident across all three groups, but the replication was weakened by the fact that Group Two did not decrease in weekly binge frequencies to the same extent as Groups One and Three. Secondly, a replication of treatment effect was evident across individual participants. In particular, three participants showed a clear treatment effect, and two others showed less distinctive treatment effects.

The results of the self-monitoring reports indicated that emotional distress was often the cause of binge episodes, and appeared to play a role in the maintenance of the problem. However, I was not able to determine whether the participants were more or less tolerant of their emotional distress before and after intervention as no measures were employed to test this variable. Interestingly, there was a considerable amount of variance in the exact emotions each participant cited as preceding their binge episodes. Boredom and stress were most frequently cited, and not knowing how to deal with these emotions effectively appeared to be the cause of many specific binge episodes. Moreover, from the comments individual participants offered in their programme evaluation questionnaires, and by the obvious reduction in binge episodes after the session on distracting techniques, teaching the skills to deal with boredom, and relaxation skills to deal with stress, were useful in improving binge eating symptoms. Other emotions, such as extreme sadness and anxiety, were also cited as precipitants.

From data obtained from the self-monitoring forms, a large difference was found between the participants' and the author's perceptions on the definition of a binge episode. This is consistent with other studies (Johnson et al., 1997; Schlundt et al., 1990). Despite the fact it seemed quite simple at face value, it proved to be more difficult to define a binge than was first anticipated. To reach a point where a binge episode could be easily recognised, it took some group discussion, and, occasionally, one-on-one discussion between individual participants and the author. Such discussions on the definition of a binge episode seemed to really help some participants who thought that nearly everything they ate was a binge. This false perception of a binge also reflects the results of previous research (Wilson et al., 1999; Williamson et al., 1991; Rossiter et al., 1990). Redefining a

binge episode from what participants had originally believed, to what is generally agreed on in the literature, went a long way to not only relieving a significant amount of guilt experienced when food was consumed, but it also enabled participants to take the next step towards gaining control over their binge eating problem.

It should be noted that the reduction in binge episodes recorded in the self-monitoring data from baseline to post-intervention did not only occur due to definitional issues. As can be seen from the graphs on individual participant binge episodes, the majority of participants did not show clear treatment effects until well into the programme. This is especially true for Groups One and Three, where the number of binge episodes reported began to reduce steadily from week four to the end of the programme. Therefore, it can be concluded that while redefining a binge episode helped some participants by relieving the guilt they reported surrounding their eating generally, the reduction in reported binge episodes from baseline to the end of the programme cannot wholly be attributed to an overreporting bias. However, future researchers and therapists should be aware that binge definition should be considered an important part of any intervention for treating binge eating problems.

In a recent investigation on the natural course of a community sample of women with binge eating disorder, 10 of the 21 participants (of those that did not drop out of the study) appeared to be in partial remission (Cachelin et al., 1999). However, the treatment effects documented in the current study did not seem to have occurred from spontaneous recovery. The reduction in binge frequency recorded was observed not only in Group One, but was also replicated in Group Three. Moreover, to fit the criteria for binge eating disorder according to the QEWP, participants were required to have been engaging in binge episodes twice weekly for at least six months. The long-term disordered eating present in all participants before they attended the programme, and the replication of treatment effects observed in Group One and subsequently in Group Three, lend support to the hypothesis that the decrease binge eating frequency was attributable to the intervention and not spontaneous recovery. A longer baseline data collection, however, is necessary for a strong conclusion to be made on the question of spontaneous recovery.

At baseline, all 11 participants met the criteria for binge eating disorder according to the QEWP. At post-treatment, only one participant continued to meet the criteria for BED according to this measure, and at follow-up no participant met the criteria for BED. The results revealed a significant reduction in scores on the BES from pre- to post-intervention, and no change from post-intervention to follow-up. While the mean score at baseline was above the recommended cut-off score of 27, the post-intervention and follow-up mean scores were well below. The effect size of the BES from pre- to post-intervention was large, and from post-intervention to follow-up was small. Thus, not only did the programme succeed in improving binge eating problems, these changes remained stable or improved over time. This provides further evidence for the hypothesis that teaching emotional discrimination and management skills makes an effective contribution to treating binge eating disorder.

It should be noted that the BES and QEWP were not always in agreement, and frequently the participants met the criteria for binge eating disorder according to one questionnaire and not the other. This discrepancy is consistent with other investigations (e.g., Gladis, Wadden, Foster, Vogt, & Wingate, 1998). The low level of agreement between scales indicates that both measures contains strengths as well as weaknesses (Gladis et al., 1998). This reflects the need for a psychometric test that incorporates the strengths of both the BES and the QEWP for assessing binge eating disorder.

The measures of emotional intelligence did not increase to a statistically significant level from pre- to post-intervention, nor did they improve from post-intervention to follow-up. However, the results may have proven to be significant if the sample size had have been larger. Moreover, the mean score from pre-intervention did increase after post-intervention, indicating that while emotional intelligence did not improve to a statistically significant level, it did increase to a considerable degree. Furthermore, the results showed that scores on the TAS reduced to a statistically significant degree from pre- to post-intervention, and continued to decrease from post-intervention to follow-up. Thus, the level of alexithymia decreased substantially after the programme, and continued to

improve at follow-up. The EI and TAS were negatively correlated, indicating that alexithymia and emotional intelligence are reversely related. This also provides convincing support for the hypothesis that those with binge eating disorder have deficits in emotional intelligence, and teaching emotional recognition and management skills that address these needs improves binge eating and related symptomatology.

The results revealed that depression reduced to a statistically significant level after the programme. This improvement in depression stayed stable over time and did not change from post-intervention to follow-up. Anxiety measured in the DASS, however, did not reduce significantly after the programme. Thus, future treatments on binge eating problems should address problematic anxiety separately.

It is interesting to note that while it could be interpreted that actual stress measured in the DASS remained unchanged, *perceived stress* measured in the PSS reduced to a statistically significant degree from baseline to post-intervention. This indicates that while actual stress in the participants' lives stayed the same, the way in which they perceived either the stress, or their ability to cope with stressful situations, improved after participating in the programme. Further, this improvement in perceived stress remained stable over time. The finding that both perceived stress and binge eating problems improved significantly provides support for the hypothesis that those with binge eating problems cope with their emotional distress by binge eating. It could be argued that the participants in this study did not engage in binge eating as a way of coping after attending the programme as they may have perceived that they could cope with stress more effectively. However, perception of ability to cope with stress was not measured directly.

The results of actual coping style revealed mixed results. The means for the adaptive coping styles increased from pre- to post-intervention, and the means for the maladaptive coping styles decreased. Adaptive and maladaptive coping styles, however, failed to attain statistical significance. While there was no change in the adaptive coping styles from post-intervention to follow-up, there was a statistically significant decrease in the use of maladaptive coping. Thus, while adaptive coping styles remained stable from post-

intervention to follow-up, maladaptive coping styles improved substantially after the programme. This may represent an artifact of response styles for answering the COPE questionnaire, as those who tended to report using many adaptive coping strategies also reported using many maladaptive coping strategies, and vice versa. It may indicate, however, that adaptive and maladaptive coping styles are distinct and are not necessarily concurrently influenced.

Like the scores from the COPE on adaptive coping styles, the ATSS data indicated a noticeable increase in adaptive and decrease in maladaptive coping responses from pre- to post-intervention, in response to both the neutral and emotion-evoking scenarios. Thus, the results of the ATSS data reflect that of the COPE. As the ATSS paradigm was designed to extract information on actual behaviour, the fact that the data from the ATSS and the COPE produced similar results indicates that the participants answered the COPE questions in a way congruent with their behaviour. This is true for baseline and post-intervention answers to the COPE. Although the ATSS data was not collected, this is also likely to be the case at follow-up.

In categorising the ATSS data, the idea unit “critical evaluation of the self” was left in a category of its own as these statements provided useful information as to how the person viewed themselves. It was hoped that by the end of the programme the participants would view themselves in a more positive light, and thus make fewer critical statements about themselves. The results of the ATSS data indicated that the participants made fewer critical statements after the programme, indicating that they did indeed view themselves in a more positive way.

Although the self-regulation writing task was not used for data collection purposes, it did prove useful in focusing the participants’ attention to their emotions (see Appendix 6 for the Programme Manual which describes this task). Every participant completed the self-regulation writing task for homework, as either they were not able to remember a recent event that had led them to binge within the session when asked to, or they were not able to write about their deepest thoughts and feelings about the event within a group setting.

Each participant described in a group discussion how they had experienced the self-regulation writing task in the next session. Although the majority of the participants found the task useful in focusing their attention on their thoughts and feelings regarding a particular stressful event, some participants noted that they did not enjoy writing as a whole, and consequently did not find the task useful. In addition, very few participants actually put into practice their solution to their problem that they had identified. More often than not, the participants preferred to use the self-regulation writing task for expressing their thoughts and feelings about an event. Having written about the event in detail using the self-regulation writing task, participants preferred to use the seven-step problem solving process for identifying problem solving strategies (see Appendix 6 for the Programme Manual which outlines the seven-step problem solving strategy). This would indicate that an integration of both strategies would be useful for improving problem solving skills in those with binge eating problems who enjoy writing. Those participants that did not enjoy writing described expressing their deepest thoughts and feelings orally to either a friend, or just out-loud, as helpful. For these participants, getting somebody they trusted to write out the answers to the seven steps problem solving form was found to be a useful technique in identifying plausible solutions to problems.

Notably, the participants in the third group both resisted completing the self-regulation writing task for several weeks. Each week they were asked to produce their homework on the task, until they had completed it. Additionally, they were asked to complete an extra writing task that the participants in the previous groups were not asked to do. This task was intended to focus their attention on why they resisted writing about their emotions and thoughts about a stressful event. Both participants described not wishing to think about their feelings, and stated that they preferred to ignore them, which was then discussed as a group. It is often noted that those with BED use avoidance coping, and this may be an example of this tendency. Thus, this extra exercise may prove useful in future treatments of BED for reluctant patients.

The social validation measures were documented from the programme evaluation questionnaire. Only one participant indicated that she did not enjoy the programme, which she stated was because it meant she had to acknowledge and address her binge eating problem. Every other participant indicated that they did enjoy the programme, and found it useful in dealing with various areas of their binge eating problem. Further, most of the participants stated that they would, or already had, recommend the programme to a family member or friend. Those that did not state that they would recommend the programme to others did not answer that question. Thus, it can be concluded that the programme used in this study was enjoyed on many levels, was found to be helpful, and would be recommended to others in the future.

Of particular interest, one of the points the majority of the participants mentioned at follow-up was that they found the timing of the programme to be problematic. The programme began in the end of August or during September, and ended during November or the beginning of December. As the programme ended during the stressful holiday season, Christmas dinners and the stress of Christmas day made it difficult to maintain the skills they had learnt, particularly meal scheduling. It is recommended that to allow the skills to be practiced to a regular degree, and to become part of their routine, this programme needs to be started at a time which avoids stressful social rituals. Alternatively, these situations could be viewed as a challenge to practice newly learnt skills and relapse prevention techniques. Unfortunately, providing extra support during the Christmas period was not possible in this study. Thus, Christmas was viewed as an obstacle rather than a challenge. The researcher or therapist should ensure that adequate support is provided during these occasions.

Lastly, although Group Three was relatively small and was difficult to run as a group, more than five or six participants per group would not be recommended for this particular programme. This is because it often utilised group discussions, which may end up running consistently overtime if too many people have something to contribute. This could result in either a rushed approach, or possibly missed information. Thus, from this

study, it appears that three to six participants per group would produce optimal results for treating binge eating problems with this particular psychoeducational programme.

ISSUES THAT NEED ADDRESSING; DIRECTIONS FOR FUTURE RESEARCH

This research needs replication so that firmer conclusions can be made regarding the effectiveness of using a psychoeducational programme that teaches emotional discrimination and management to those with BED.

This study had several limitations, the most notable of which was that this study employed a self-selected sample of 11 individuals, the majority of whom were New Zealand European. Further, the participants were not randomly selected for groups due to availability constraints. Thus, replications need to be done with larger sample sizes, and with randomly selected groups to determine whether the same effects that occurred in this research can be replicated. Further, a longer term follow-up of at least six months is also needed to assess the robustness of the treatment effects. In addition, as BED appears to occur at similar rates among different ethnic groups, future research needs to compare the effect of teaching emotional discrimination and management to individuals of varying ethnic backgrounds.

Most importantly, the study of binge eating disorder would benefit from a replication using male participants, as this study employed only female participants. Research such as this may help determine the etiology of binge eating disorder in males, as it is not yet known whether males binge as a result of cues other than emotional ones, or whether, due to social pressure, do not admit to binge eating as a result of emotional distress (Tanofsky et al., 1997). However, in a replication using male participants this particular programme would need to be adjusted. For instance, examples and analogies more appropriate to males are needed, as many of the examples used were written specifically for female participants, to help increase their understanding.

Moreover, this study exclusively relied on self-report questionnaires to recruit participants, which is why the focus was on improving binge eating problems and not treating binge eating disorder. As questionnaires on BED do not provide precise definitions as to what constitutes a binge episode, they can only offer an unrefined indication of overall symptomatology (Smith, Marcus, & Eldredge, 1994). It is recommended that future research employs trained clinicians to perform structured interviews to recruit and evaluate their participants.

In addition, the programme employed in this study lasted only ten weeks. Future research should be performed using a slightly longer programme. Not only would this allow the researcher to spend more time on the areas that were covered in this programme, but a longer programme could also incorporate extra sessions on issues and skills that have not been addressed or taught in this investigation. Lengthening the programme to the degree of DBT, however, should be avoided. Further, while the programme itself may only require one or two more sessions to produce greater results, more support or booster sessions may be required to maintain further treatment effects. This would allow discussions between the participants and the therapist regarding recent problems and issues, without complicating matters with additional new material. Solutions to these problems could then be worked out using the information learnt throughout the programme.

Another limitation is that this study could not be used to establish whether some parts of the programme were found to be more useful than others as reports were inconsistent (see the *Social Validation Measures* in the results section). Further research that measures the effectiveness of each component in this programme for treating binge eating problems may be required for optimal results.

Lastly, as obesity is strongly associated with binge eating disorder, and carries serious physiological and psychological risk factors of its own, treatment for BED should include a subsequent weight management programme. This should be provided after treatment for BED, as once binge eating episodes are reduced and the individual has normalised

their eating behaviour, weight loss will be better achieved (Smith, Marcus, & Eldredge, 1994; Agras, 1993; 1995; 1999, Agras et al., 1997.)

CONCLUSION

This study provides tentative evidence for the hypothesis that teaching emotional discrimination and management skills, with the aim of improving emotional intelligence, is effective in treating binge eating disorder. It provides support for the affect regulation model of binge eating disorder, and for the use of a shorter, less complex treatment than DBT. However, many issues need to be addressed in future investigations before this can be known conclusively.

Thanks must go to all my participants for all their support. Particular thanks must go to the participant who explained that out of all the programmes, courses and counsellors she had previously seen, this programme was the only one that helped at all. Also special thanks must go to the participant who stated after only a few short weeks of attending this programme, she noticed that her life seemed to be so much easier and stress free. These and other similar comments are what made all the effort that went into writing the programme, not to mention organising groups, worth while.☺

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APPENDIX 1

ADVERTISEMENT FOR THE UNIVERSITY OF CANTERBURY AND THE COLLEGE OF EDUCATION

WOMEN VOLUNTEERS WANTED

EMOTIONAL BINGE EATING

Department of Psychology
University of Canterbury

This project has been approved by the Ethics Committee.

Women volunteers are wanted for research on emotional binge eating. You will be asked to fill in three short questionnaires. Shortly after, you may be invited back to participate in the programme which involves learning new skills in small groups.

If you are interested, please call Courtney on 364-2564, or e-mail her on cee_s@hotmail.com.

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APPENDIX 2

ADVERTISEMENT AND EDITORIAL FOR THE MAIL



Women

Volunteers WANTED

Emotional Binge Eating

Women volunteers aged 18 or over are wanted for research on emotional binge eating. Volunteers who think they are affected by binge eating will be asked to fill in three short questionnaires. Soon after, you may be invited back to participate in a programme that involves learning new skills in small groups. Every volunteer who participates in the programme will be given a \$20 petrol voucher to help with travel costs.

CAN YOU HELP?

Please call Courtney on 364-2564 or e-mail her on cee-s@hotmail.com.

N30675671A

emotional BINGE EATING

Problems with binge eating can affect both males and females of all ages.

Research has shown that people who consume large amounts of food and drink in small amounts of time, but do not try to rid themselves of it, have a problem termed binge eating disorder.

Binge eating disorder is different from other eating disorders in that the person does not purge themselves, nor do they use excessive exercise and other means to rid themselves of the food and drink they have consumed.

Food and drink is consumed without the person necessarily feeling hungry or thirsty, and the

binge may be triggered by negative emotions or moods. Although the person may not want to eat or drink anything, they feel compelled to do so to deal with the distress they are feeling.

Thus, the person may feel out of control of their eating, and quite often, feel ashamed about their bingeing.

More often than not, binge eating problems are associated with the serious problem of obesity. While there is no evidence to say that binge eating causes obesity, it is likely that obesity is increased by binge eating

episodes. People suffering from binge eating problems often have feelings of revulsion and loathing towards their body, and as a result they often avoid seeing themselves in mirrors.

Binge eating disorder is also often associated with excessive dieting and with chaotic eating patterns.

Treatment consists of helping people regulate their eating patterns, assisting them in dealing with their emotional distress, and changing their negative attitudes towards themselves.



APPENDIX 3

INFORMATION SHEETS AND CONSENT FORMS

Department of Psychology
University of Canterbury

Information Sheet

You are invited to participate in a research project on emotional eating by completing the following three short questionnaires. Your complete anonymity is guaranteed regarding all information you give at any stage of the project. If at any time you wish to withdraw from the programme, advise me of your decision, and the information you have supplied will not be included in the project. However, if you complete the questionnaires, it will be understood that you have decided to participate in the project.

Consent Form

I have read and understood the above information, and I agree to participate in this first stage of the project by filling in three short questionnaires. I also consent to being contacted again, depending on my scores in the questionnaires.

Signed:.....Date:.....

This project has been approved by the University of Canterbury Human Ethics Committee and is being carried out by Courtney Clyne, under the supervision of Neville Blampied, as required for a Masters Degree in Psychology.

Information Sheet Two

The questionnaires you filled in will be used to measure the degree of your problems with binge eating. We need participants in a programme that deals with binge eating problems by teaching emotional recognition and coping skills. Depending on your questionnaire results, we may invite you to participate in a psychoeducational programme focused on emotions and their effects on eating, adjustment and well being.

The programme will consist of 10 sessions covered over 11 weeks, each of which will take no more than two hours at a time. After filling out 4 additional short questionnaires, you will meet the rest of your group. During this first meeting, you will be given a brief introduction to the programme and will be shown some new skills. After this session, you will be asked to monitor your eating and emotional patterns for two weeks. You will not meet with the rest of the group again until after this two week period. Your group will then meet for up to two sessions per week, which will be arranged around every member's availability. When the programme ends after 11 weeks, you will have a three month break from the programme, and will then be asked to fill in some questionnaires for a follow-up.

If you are invited back and decide to participate in the full programme, it will be understood that you consent to possible publication of the results of the project with the understanding that the information you give will remain anonymous.

Consent Form Two

I have read and understood the above information, and I agree to participate in the full programme. I also consent to the publication of the results of the project, and I understand that the information I give will remain anonymous. Further, I understand that I can withdraw from the project at any time, with the understanding that all information I have supplied will not be included in the project.

Signed:.....Date:.....

This project has been approved by the University of Canterbury Human Ethics Committee and is being carried out by Courtney Clyne, under the supervision of Neville Blampied, as required for a Masters Degree in Psychology.

APPENDIX 4

QUESTIONNAIRES

QUESTIONNAIRE ON EATING AND WEIGHT PATTERNS-REVISED (QEWP-R)©

Robert L. Spitzer, Susan Z. Yanovski, Marsha D. Marcus

Name _____ Date _____

Thank you for completing this questionnaire. Please circle the appropriate number or response, or write in information where asked. You may skip any question you do not understand or do not wish to answer.

1. Age _____ years
2. Sex: 1 male 2 female
3. What is your ethical/racial background?
 1. New Zealand European
 2. Maori
 3. Pacific Island
 4. Asian
 5. Other (please specify) _____
4. What is your highest academic achievement?
 - a. School certificate or equivalent
 - b. Sixth form certificate
 - c. High school graduate
 - d. University, polytechnic or other tertiary degree or diploma
5. How tall are you?
_____cms
6. How much do you weigh now?
_____kgs
7. What has been your highest weight ever (when not pregnant)?
_____kgs
8. Have you ever been overweight by at least 5kg as a child, or 10kg as an adult (when not pregnant)?

1 Yes	2 No or not sure
-------	------------------

If yes: How old were you when you were first overweight (by at least 5kg as a child or by 10kg as an adult)? If you are not sure, what is your best guess?
_____ years
9. How many times (approximately) have you lost 9kg or more – when you weren't sick – then gained it back?
 - a. Never
 - b. Once or twice
 - c. Three or four times

d. Five times or more

10. During the past **six** months, did you often eat within any two hour period what most people would regard as an unusually large amount of food?

1 Yes 2 No

If no: Skip to question 15.

11. During the times when you ate this way, did you often feel you couldn't stop eating or control what or how much you were eating?

1 Yes 2 No

If no: Skip to question 15.

12. During the past **six** months, how often, on average, did you have times when you ate this way – that is, large amounts of food **plus** the feeling that your eating was out of control? (There may have been some weeks when it was not present – just average those in.)

- a. Less than one day a week
- b. One day a week
- c. Two or three days a week
- d. Four or five days a week
- e. Nearly every day

13. Did you **usually** have any of the following experiences during these occasions?

- | | | |
|--|-----|----|
| a. Eating much more rapidly than usual? | Yes | No |
| b. Eating until you felt uncomfortably full? | Yes | No |
| c. Eating large amounts of food when you didn't feel physically hungry? | Yes | No |
| d. Eating along because you were embarrassed by how much you were eating? | Yes | No |
| e. Feeling disgusted with yourself, depressed, or feeling guilty after overeating? | Yes | No |

14. Think about a typical time when you ate this way – that is, large amounts of food **plus** the feeling that your eating was out of control.

1. What time of the day did the episode start?

- a. Morning (8am to 12 noon)
- b. Early afternoon (12 noon to 4pm)
- c. Late afternoon (4pm to 7pm)
- d. Evening (7pm to 10pm)
- e. Night (after 10pm)

2. Approximately how long did this episode of eating last, from the time you started to when you stopped and didn't eat again for at least two hours?

_____ hours _____ minutes

3. As best you can remember, please list everything you might have eaten or drunk during that episode. If you ate for more than two hours, describe the foods eaten and liquids drunk during the two hours that you ate the most. Be

specific – include brand names where possible, and amounts as best you can estimate. For example, 35g of Ripples salt and vinegar chips; 1 cup of Tip Top chocolate ice-cream with 2 teaspoons of hot fudge; 2 cans of coke; 1½ ham sandwiches with cheese and mustard.)

4. At the times this episode started, how long had it been since you had previously finished eating a meal or snack?
 _____ hours _____ minutes

15. In general, during the past **six** months, how upset were you by overeating (eating more than you think is best for you)?

- a. Not at all
- b. Slightly
- c. Moderately
- d. Greatly
- e. Extremely

16. In general, during the past **six** months, how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

- a. Not at all
- b. Slightly
- c. Moderately
- d. Greatly
- e. Extremely

17. During the past **six** months, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people?

- a. Weight and shape were **not important**
- b. Weight and shape **played a part** in how you felt about yourself
- c. Weight and shape **were among the main things** that affected how you felt about yourself
- d. Weight and shape **were the most important things** that affected how you felt about yourself.

18. During the past **three** months, did you ever make yourself vomit in order to avoid gaining weight after binge eating?

- 1 Yes
- 2 No

If yes: How often, **on average**, was that?

- a. Less than once a week
- b. Once a week
- c. Two or three times a week
- d. Four or five times a week
- e. More than five times a week

19. During the past **three** months, did you ever take more than twice the recommended dose of laxative in order to avoid gaining weight after binge eating?

- 1 Yes 2 No

If yes: How often, **on average**, was that?

- a. Less than once a week
- b. Once a week
- c. Two or three times a week
- d. Four or five times a week
- e. More than five times a week

20. During the past **three** months, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating?

- 1 Yes 2 No

If yes: How often, **on average**, was that?

- a. Less than once a week
- b. Once a week
- c. Two or three times a week
- d. Four or five times a week
- e. More than five times a week

21. During the past **three** months, did you ever fast – not eat anything at all for at least 24 hours – in order to avoid gaining weight after binge eating?

- 1 Yes 2 No

If yes: How often, **on average**, was that?

- a. Less than one day a week
- b. One day a week
- c. Two or three days a week
- d. Four or five days a week
- e. Nearly every day

22. During the past **three** months, did you ever exercise for more than an hour **specifically** in order to avoid gaining weight after binge eating?

- 1 Yes 2 No

If yes: How often, **on average**, was that?

- a. Less than once a week
- b. Once a week
- c. Two or three times a week

- d. Four or five times a week
- e. More than five times a week

23. During the past **three** months, did you ever take more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating?

- 1 Yes 2 No

24. During the past **six** months, did you go to any meeting of an organised weight control programme (Eg. Weight watchers, Jennie Craig) or a self-help programme (Eg. Overeaters Anonymous)?

- 1 Yes 2 No

If yes: Name the programme _____

25. Since you have been an adult – 18 years old – how much of the time have been on a diet, been trying to follow a diet, or in some way been limiting how much you were eating in order to lose weight or keep from regaining weight you had lost? Would you say....

- a. None or hardly any of the time
- b. About a quarter of the time
- c. About half of the time
- d. About three-quarters of the time
- e. Nearly all of the time

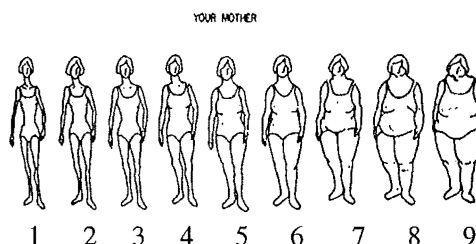
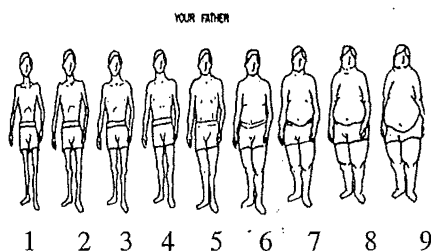
26. SKIP THIS QUESTION IF YOU HAVE NEVER LOST AT LEAST 4.5KG BY DIETING: How old were you the first time you lost at least 4.5kgs by dieting, or in some way limiting how much you ate? If you are not sure, what is your best guess?

_____ years

27. SKIP THIS QUESTION IF YOU'VE NEVER HAD EPISODES OF EATING UNUSUALLY LARGE AMOUNTS OF FOOD ALONG WITH THE SENSE OF LOSS OF CONTROL: How old were you when you first had times when you ate large amounts of food and felt that your eating was out of control? If you are not sure, what is your best guess?

_____ years

28. Please take a look at these silhouettes. Put a circle around the silhouettes which most resemble the body build of your natural father and mother **at their heaviest**. If you have no knowledge of you biological father and/or mother, don't circle anything for that parent.



QUESTIONNAIRE ON EATING AND WEIGHT PATTERNS-REVISED
(QEWP-R)©

Robert L. Spitzer, Susan Z. Yanovski, Marsha D. Marcus

Name _____ **Date** _____

Thank you for completing this questionnaire. Please circle the appropriate number or response, or write in information where asked. You may skip any question you do not understand or do not wish to answer.

1. Age _____ years
2. Sex: 1 male 2 female
3. What is your ethical/racial background?
 1. New Zealand European
 2. Maori
 3. Pacific Island
 4. Asian
 5. Other (please specify) _____
4. What is your highest academic achievement?
 - a. School certificate or equivalent
 - b. Sixth form certificate
 - c. High school graduate
 - d. University, polytechnic or other tertiary degree or diploma
5. How tall are you?
_____cms
6. How much do you weigh now?
_____kgs
7. What has been your highest weight ever (when not pregnant)?
_____kgs
8. Have you ever been overweight by at least 5kg as a child, or 10kg as an adult (when not pregnant)?
 - 1 Yes 2 No or not sure

If yes: How old were you when you were first overweight (by at least 5kg as a child or by 10kg as an adult)? If you are not sure, what is your best guess?
_____ years
9. How many times (approximately) have you lost 9kg or more – when you weren't sick – then gained it back?
 - a. Never
 - b. Once or twice
 - c. Three or four times

d. Five times or more

10. During the past **two** months, did you often eat within any two hour period what most people would regard as an unusually large amount of food?

1 Yes 2 No

If no: Skip to question 15.

11. During the times when you ate this way, did you often feel you couldn't stop eating or control what or how much you were eating?

1 Yes 2 No

If no: Skip to question 15.

12. During the past **two** months, how often, on average, did you have times when you ate this way – that is, large amounts of food **plus** the feeling that your eating was out of control? (There may have been some weeks when it was not present – just average those in.)

- a. Less than one day a week
- b. One day a week
- c. Two or three days a week
- d. Four or five days a week
- e. Nearly every day

13. Did you **usually** have any of the following experiences during these occasions?

- | | | |
|--|-----|----|
| a. Eating much more rapidly than usual? | Yes | No |
| b. Eating until you felt uncomfortably full? | Yes | No |
| c. Eating large amounts of food when you didn't feel physically hungry? | Yes | No |
| d. Eating along because you were embarrassed by how much you were eating? | Yes | No |
| e. Feeling disgusted with yourself, depressed, or feeling guilty after overeating? | Yes | No |

14. Think about a typical time when you ate this way – that is, large amounts of food **plus** the feeling that your eating was out of control.

1. What time of the day did the episode start?

- a. Morning (8am to 12 noon)
- b. Early afternoon (12 noon to 4pm)
- c. Late afternoon (4pm to 7pm)
- d. Evening (7pm to 10pm)
- e. Night (after 10pm)

2. Approximately how long did this episode of eating last, from the time you started to when you stopped and didn't eat again for at least two hours?

_____ hours _____ minutes

3. As best you can remember, please list everything you might have eaten or drunk during that episode. If you ate for more than two hours, describe the foods eaten and liquids drunk during the two hours that you ate the most. Be

specific – include brand names where possible, and amounts as best you can estimate. For example, 35g of Ripples salt and vinegar chips; 1 cup of Tip Top chocolate ice-cream with 2 teaspoons of hot fudge; 2 cans of coke; 1½ ham sandwiches with cheese and mustard.)

4. At the times this episode started, how long had it been since you had previously finished eating a meal or snack?
 _____ hours _____ minutes

15. In general, during the past **two** months, how upset were you by overeating (eating more than you think is best for you)?

- a. Not at all
- b. Slightly
- c. Moderately
- d. Greatly
- e. Extremely

16. In general, during the past **two** months, how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

- a. Not at all
- b. Slightly
- c. Moderately
- d. Greatly
- e. Extremely

17. During the past **two** months, how important has your weight or shape been in how you feel about or evaluate yourself as a person – as compared to other aspects of your life, such as how you do at work, as a parent, or how you get along with other people?

- a. Weight and shape were **not important**
- b. Weight and shape **played a part** in how you felt about yourself
- c. Weight and shape **were among the main things** that affected how you felt about yourself
- d. Weight and shape **were the most important things** that affected how you felt about yourself.

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- 1 Yes 2 No

If yes: Name the programme _____

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- a. None or hardly any of the time
- b. About a quarter of the time
- c. About half of the time
- d. About three-quarters of the time
- e. Nearly all of the time

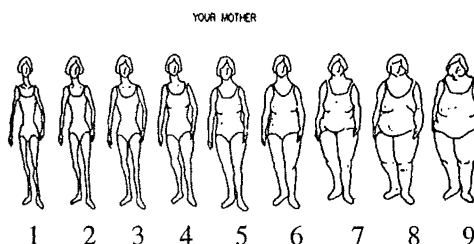
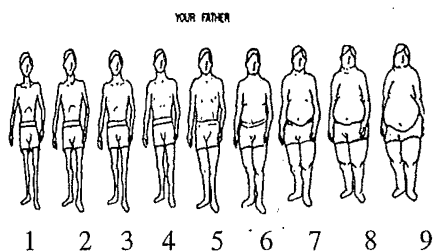
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_____ years

28. Please take a look at these silhouettes. Put a circle around the silhouettes which most resemble the body build of your natural father and mother **at their heaviest**. If you have no knowledge of you biological father and/or mother, don't circle anything for that parent.



APPENDIX 5

LETTER TO PARTICIPANTS DISPLAYING BULIMIC SYMPTOMS

13 August, 2001

Participant Name
Address
Address
CHRISTCHURCH

Dear Participant,

I am writing to let you know that you have not been chosen to participate in the emotional binge eating programme.

Having reviewed your answers in the questionnaires you filled in, my supervisor and I noticed that you seem to have symptoms that are commonly found in bulimia nervosa. Although we are not able to offer you a diagnosis as to whether or not you have bulimia nervosa, we would like to recommend that you speak to your general practitioner regarding your eating and any related problems you may have.

To help your GP, we are willing to give them a report outlining the results of the questionnaires you filled in. We will not do this unless you personally ask for our report.

Thank you for taking the time to come and fill in the questionnaires. We really appreciate your time and efforts. If you would like to speak to me regarding this letter, please call me on *phone number*.

Take care.

Yours sincerely,

Courtney Clyne.

APPENDIX 6

PROGRAMME MANUAL INCLUDING HANDOUTS TO PARTICIPANTS

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permission of the author.*

SESSION ONE

THE IMPORTANCE OF SELF-MONITORING

1. Introductions to be made

- ♣ Everyone to be given a name tag
- ♣ I introduce myself and why I'm doing this. Generally talk about interests outside of this group
- ♣ Have everyone introduce themselves to their neighbour, and then to the group (depending on how the group appears in terms of confidence, they can either introduce themselves or the person next to them).

2. Brief introduction on the rationale of the programme

- ♦ Give the participants the Programme Outline handout (*note: any further handouts are added after the homework on each session*)
- ♦ Explain that every lesson will end with a small homework assignment. These will vary in difficulty levels, but none are beyond anyone here.
- ♦ Each session will start with a review of the previous day's homework, and how each individual found it.

PROGRAMME OUTLINE

How long will it take?

- ♣ From the start to finish, the programme will take 11 weeks
- ♣ But there will also be a 3-month follow-up (during which we will not meet until the end of the 3-month period).
- ♣ There will be 10 sessions
- ♣ Each session will take up to 2 hours, with a 15 minute break at half time.

What will be covered in the programme?

- ♣ This session will introduce the skill of self-monitoring
- ♣ The next session will cover meal and snack planning, and a table of emotions will be given out to help you identify your emotions
- ♣ Secondly, we will discuss the influence of emotions on
 - a. life in general, and
 - b. your eating patterns
- ♣ You will then learn how to recognise your emotions.
- ♣ Then you will learn relaxation skills, which will include how relaxation skills can be used to help you through managing your binge eating problems in every day life.
- ♣ You will then learn how to manage your problems more effectively.
- ♣ This will be followed by assertion training
- ♣ And the programme will finish with maintenance training, that is, how you can maintain the improvements you have made on your binge eating problems throughout the programme.

What is expected to be achieved through my taking part in the programme?

1. You will learn how to recognise different emotions.
 2. You will also learn how situations are linked to emotions, and how emotions are linked to binge eating episodes and behaviours.
 3. Most importantly, you will learn how to manage your emotions.
 4. The programme will give you skills to manage the emotions that precipitate binges, and thus will give you control over whether or not you binge.
- Depending on how you use the skills and the choices you make, your ability to cope with emotions and eating should be improved.

What is expected of me?

1. You are expected to turn up to each session on time, particularly as a lot of information is covered in a short amount of time. Also, in some instances, somebody may be telling the group something very personal to them and should not be interrupted.
2. Every participant is expected to give their full commitment to the programme to allow it to have its full effect. Thus, every one is expected to complete the small homework assignments that are set and to continue throughout the programme with the self-monitoring task. Just as is the case with everything in life, the more effort you put in, the greater the reward at the end.
3. Every one is expected to give their full participation in the group discussions and to be completely honest with the group. Remaining silent throughout these groups will not benefit you or the others in your group. If you feel you have nothing to contribute at some stage, that's fine. However, it is expected that every one will have something to contribute throughout the programme.
4. You are expected to acknowledge and respect the privacy of others at all times. Thus, what is said in the session room remains in the session room. If any participant wishes to discuss something that was said in group outside of group time, they are welcome to discuss it with me afterwards. Confidentiality is expected of every one involved in the group.

Please sign the page below to indicate that you agree to these conditions

- a. I will turn up to every session, and on time***
- b. I will give my full commitment to the programme, including fulfilling the homework tasks and self-monitoring task.***
- c. I will participate fully in group discussion, and will be honest with myself and the group***
- d. I will respect the privacy of others, and will respect the confidentiality requirements at all times.***

*I,.....understand my responsibilities as listed above,
and I agree to abide by them.*

Signed.....Date.....

5. Brief description of planned sessions

Week	Session	Component
1	1	Introduction to self-monitoring
2		Week one of two in baseline Week two of two in baseline
3	2	Basic recognition and
4	3	Basic nutrition component Emotional influence
5	4	Specific emotions
6	5	Relaxation training
7	6	Relaxation training (1/2) and
8	7	Differential relaxation training (1/2) Problem solving skills
9	8	Assertion training
10	9	Maintenance
11	10	Maintenance

THE IMPORTANCE OF SELF-MONITORING

Self-monitoring involves you observing and recording you own behaviours (in this case, your own binge eating behaviours), the events that happened before your behaviour, and what happened after the behaviour.

This can mean recording places, names, situations, EMOTIONS, other people who are involved etc.

There are two main purposes of self-monitoring;

- a. It can provide a detailed and accurate picture of your eating behaviours and emotions. In this way, it can bring your attention to the factors surrounding your eating problem.
- b. It can make you aware of your behaviour at the time of which you are doing it. Thus, self-monitoring can help you change your behaviour that you may have thought was automatic or beyond your control.

The benefits of recording this information (self-monitoring)

- ◆ As has already been mentioned, self-monitoring helps you see clearly what factors are causing you to binge. Every one is different and may have different things that cause them to binge eat. You may have things going on in your life even you aren't aware of, and writing these things down can help clarify the difficult areas in your life.
- ◆ This means you can define clearly what steps you need to make to change your binge eating patterns.

- ◆ Then, this allows you to make these changes according to what is really going on in your life. Self-monitoring can empower you to make changes where they are really needed and where they will count most.
- ◆ If you continue to record after you have reduced or stopped your binge eating behaviours, you will also be able to see clearly how these changes you have made are benefiting you.

Thus, you can see clearly where changes need to be made, you are more able to make the relevant changes that will directly improve your life, and you won't make changes that aren't necessary or that won't benefit you.

How this is best done and what to avoid

At first self-monitoring may seem artificial and inconvenient. However, if you persist, you will notice the benefits of carrying on with it and it will become second nature to you.

Self-monitoring is a very useful thing to do, but may not be beneficial in certain circumstances.

1. Make sure you record your behaviours, emotions, and situation honestly and as accurately as you can. Keep in mind that the more honest and accurate you are, the more it will benefit you as you can see what is truly going on.
2. Write down everything you eat, including your meals. Put brackets around the planned meals and snacks so that they can be separated from the binge eating episodes. If you miss out information, you will not benefit as much as you would if everything is recorded.
3. Record your answers as soon after the event as you can. This will help you be more accurate, because even if you have a great memory, your level of accuracy can be reduced by leaving it too long before writing it down.
4. Be persistent. Although self-monitoring isn't much fun, it is very important as it allows you to become aware of your emotions and other factors that may be influencing your binge eating behaviours.

What the columns mean

(see the example provided)

1. Date
 - ◆ Helps identify how often you binge eat
 - Time
 - ◆ Helps identify if there are any specific times of the day that are of high risk
2. Where were you?
 - ◆ In this column you write exactly where you were (to help identify high risk places. Note, if it was in your own home, specify the exact room).

3. What was going on?
 - ◆ Write who else was there,
 - ◆ and give a detailed description of the situation
4. How did you feel?
 - ◆ Write your emotions in this column that you felt before you binged.
 - ◆ Include any strong emotions you feel at the time.
 - ◆ This column tracks your emotional response to the situation, and your emotional triggers for binge eating (which may be different for each individual).
5. What did you eat or drink in response?
 - ◆ This helps identify high risk foods and drinks, and allows us to identify the extent of your binge (ie. the seriousness of the binge episode).
 - ◆ Just write down what it was you consumed and how much in simple terms, there's no need to write down the calorie content or any other technical details.
 - ◆ However, it can be helpful if you identify particular brand names and flavours (eg. Ripples salt and vinegar chips, 35g).
6. How did you feel afterwards?
 - ◆ Write your specific emotions in this column that you felt after you finished bingeing.
 - ◆ This helps identify how you feel (ie. the emotional consequences) after you have binged.
 - ◆ This will allow you to see how damaging your behaviour is to not only your life in general, but to your emotional health as well.
7. What did you do?
 - ◆ This allows us to determine the pattern your binge eating and consequences take.
 - ◆ It is hoped you will be able to see clearly how changing these behaviours will benefit your psychological and emotional adjustment and well-being.

THIS WEEK'S HOMEWORK

- ※ To monitor your eating patterns, including binge eating episodes.
- ※ Hand out a copy of the self-monitoring forms to each participant. Get them to remember what they have eaten today, and to fill in the forms. (The purpose being to not only check that they understand how to use the forms, but also to point out that recording is harder when done in retrospect.)
- ※ Check the participant's forms for understanding, and give them all 14 more each (this should last the next fortnight). Remind them of the importance of filling these in correctly, and note that this will be done for the rest of the programme.
- ※ Make it clear to the participants that we will not meet again until after the next 2 weeks. Clarify with them the arranged time and place, and make sure it is still suitable.

SESSION TWO

DEFINING A BINGE

- * *Start this session with a hand out of the Table of Emotions*

This table is meant to be used when you're filling out your self-monitoring forms. The table is just a list of emotions to help you to decide which emotions you are feeling at the time of a binge eating episode.

- * REVIEW OF HOMEWORK

- * Check everybody's forms separately to make sure they understand how it's done

Group discussion; were there any problems with monitoring your eating habits? Did anyone find it useful in learning about their eating habits?

- * Tell them that from now on, not all eating habits will be recorded – after today, everyone will only record their binge eating episodes (which is what the forms are designed for).
- * Today you will learn how to recognise a binge episode (which you may or may not have already known). This knowledge will help you fill the forms in correctly.

1. What is a binge?

Group Discussion; how do you define a binge?

- ♣ A binge may be a large amount of food and liquid consumed in a certain amount of time. The word binge is often associated with the image of an unplanned, excessive bout of overeating.
- ♣ But it can also be a small amount of food and drink consumed in a specific amount of time.
- ♣ Also, the length of time can last only minutes, or it can last from the moment you wake up to the time you go to bed.

2. Apart from a lot of food, what else is associated with a binge episode?

Group Discussion; how do you feel during a binge eating episode? What feelings do you often associate with a binge?

- ♣ The most important thing to recognise when you're deciding if you are binge eating or not is the feeling of being out of control.
- ♣ If you feel out of control, you are binge eating.
- ♣ So, it may not be how much food or drink you consume, or how long it takes to do so, **but whether or not you feel out of control.**

- ♣ This feeling is also accompanied by a strong feeling of fear:- of not being able to resist eating, or of not being able to stop once you've started.

3. How often do binges happen for people who have binge eating problems?

Group Discussion; how often do you binge within a week or within a month?

- ♣ On average, binge episodes occur twice a week.
- ♣ Even if you don't meet the criteria for binge eating disorder, if you consider that binge eating is negatively affecting your life, then it is time to do something about it.

4. Two different types of binge episodes

- a. *A spontaneous binge eating episode; caused by*
 - some emotional event,
 - or too heavy dietary restrictions you place on your eating
- b. *A delayed binge eating episode; caused by*
 - an emotional event but is not likely to be caused by over ambitious diets.

Group Discussion; which one can you identify with most?

5. Important defining moment

- ♣ The deciding factor on whether what you are eating could be considered a binge is up to you. Whether **you** label your eating behaviour as a binge at the time will determine whether it is or not.

So, life without binging means

- Eating when you decide according to your schedule
- Not eating when eating is not scheduled unless you decide to (e.g., social situations)

Goal:

- A) You eat regular, planned meals
- B) You control your eating and make conscious decisions to eat (i.e., you do not respond to impulse or urges.)

Individual Work; Can you think of any other factors the experts have missed?

Group Discussion; discuss any questions or issues participants have. Did they come up with any suggestions? Discuss these.

BREAK FOR 15 MINUTES

BASIC NUTRITION COMPONENT

It should be noted that the following is just some tips for introducing healthy eating patterns into your life and intended to demonstrate some strategies that may help you adopt these habits. However, if you do decide to make some drastic changes to your eating habits, please consult a doctor or nutritionist to get the latest, up-to-date information and a plan that suits you best.

The saying “you are what you eat” has two different meanings. Firstly, the most common interpretation of this saying is that your diet can determine how you look, act, and feel.

The second is that

“food and the human body are made up of the same classes of chemicals: water, carbohydrates, fats, proteins, vitamins, and minerals...Each of these classes makes identifiable contributions to the metabolic processes of all cells of the body.”

(Greenfield, 1985, p.293-294.)

Group Discussion; how much do you know about nutrition already? List the 5 important types of nutrients, do you know how much we need to eat out of the food groups?

There are 5 types of nutrients that we need from food;

1. Carbohydrates
2. Lipids (otherwise known as fats)
3. Proteins
4. Vitamins
5. Minerals

We also need fiber, but this is not considered a nutrient as we don't need it in our metabolism. We do need it for digestion though.

There are 6 food groups that we obtain these nutrients and fiber from (*See pyramid diagram; adopted from Sarafino, 1998*).

- the serving sizes vary in relation to the food group, and in relation to the food type (e.g., ¼ cup of muesli = ⅔ cup oats, or 1 ½ weetbix).

We should eat about 2-3 servings of dairy products per day, 2-3 servings of lean meat, 3-5 servings of vegetables per day, 2-4 servings of fruit per day, and 6-11 servings of grains per day.

- a. Milk and cheese – 1 serving = 1 cup of low fat yoghurt; 25g of natural cheese; or 35g of processed cheese.
- b. Meat and poultry – 1 serving = 30g of cooked lean meat, poultry or fish; 1 egg; 2 tablespoons of peanut butter; 6 tablespoons of nuts, or ¼ cup of dry peas, beans or lentils.

- c. Vegetable group – 1 serving = 1 cup of raw vegetables, ½ cup of other vegetables, or ¾ cup of vegetable juice.
- d. Fruit group – 1 serving = 1 medium apple, orange or banana.
- e. Grain group – 1 serving = 1 slice of bread; ⅔ cup of dry cereal, or ½ cup of cooked cereal, rice or pasta.

Basic nutrition tips

- ♣ 20% of your daily food intake should be made up of fat (which is recommended to be polyunsaturated or monounsaturated fats, such as that contained in peanuts, vegetable oils etc. Fats from red meats and chicken are called saturated fats (such as the fat from the skin of chicken, pork rind etc). For a nutritionally balanced lifestyle, an equal amount of saturated and unsaturated fats is important - so don't eliminate saturated ones totally from your diet.
- ♣ 60% of your daily food intake should be made up of carbohydrates
- ♣ 20% of your daily food intake should be made up of protein.

IMPORTANCE OF PLANNED MEALS AND SNACKS

Benefits of planned meals and snacks

- ♣ More energy throughout the day
- ♣ Less chance of bingeing
- ♣ Reduces the guess work (what to eat and when), which allows you to concentrate on other things
- ♣ Meals become fulfilling and guilt-free
- ♣ Less hunger will be felt throughout the day (either your body will become adjusted to eating at specific times, and will gradually stop signalling hunger between these times. Or, if you're not used to eating much during the day and only have irregular snacks rather than planned meals, you are likely to feel less hungry generally).

SCHEDULING

Group Discussion; how do you schedule your meals, if at all? What should you do, do you think?

- ♣ Plan your meals and snacks so they occur at approximately the same time every day (although this isn't an inflexible rule, as some days you may work longer hours or may not have time to have a break until later).
- ♣ Regular meals eaten at the same time every day will set your body into a routine, which will reduce how often you feel hungry (thereby reducing the risk of bingeing) and will stop you from having to think about when you should eat. Meals eaten at regular times every day also helps your digestive system to work most effectively

- ♣ Schedule your meals and snacks so they are eaten within four hours of each other (but more than 2 hours). Again, this will reduce the likelihood of you binge eating as you are less likely to feel hungry.
- ♣ Plan to have breakfast – they don't say it's the most important meal of the day for nothing!! This will kick-start your metabolism, give you more energy during the day, and reduce the risk of bingeing when morning-tea comes as you will be less hungry. Even a banana or something small will do, and you can consider increasing this amount when you become used to eating in the mornings. Note; a cup of coffee is not good enough! It gives you "false energy" (which is produced by caffeine and any sugar that is added), and won't last until the next meal.
- ♣ Figure out if you are more hungry in the mornings, during the middle of the day, or at night.
 - Schedule your meals around these hunger periods **but** keep in mind that eating very little during the day and a huge meal at night will not benefit you and your body - if you eat very little during the day, you will not reduce your risk of bingeing as you will be more likely to be hungry (even if you aren't aware of it).
 - In addition, eating a big meal at night before you go to bed does not use this meal to its full capacity. The energy from the meal will be stored in your system as you are not using it (instead, you're sleeping!), rather than using it as it is needed (during the day when you are active).
 - Sometimes it's a good idea to eat your dinner at lunch time at your lunch at dinner time. This is because you need more food (energy) during the day rather than at night. Whether you choose to do this may depend on when you are more hungry, or when you are more likely to binge.

OTHER TIPS FOR KEEPING TO SCHEDULED MEALS AND RESISTING BINGE EATING

Group Discussion; can you think of any useful strategies to resist binge eating episodes?

- ♣ *Plan your meals around your breaks.* When you have less to do (ie., less to distract yourself with) you may be more likely to binge. One strategy you could use is to plan activities that will distract you from food (such as exercise, visiting a friend who's not likely to offer you food, etc) between your meals. That is, use these activities to distract you until your next meal (which will help reduce the risk of bingeing).
- ♣ *If you exercise, try changing the time you exercise.* It has been noted that moderate exercise can curb your appetite. Plan to exercise at the times between meals that you often experience hunger pangs. This way, you may curb your appetite rather than binge eating or eating your meal too early.
- ♣ *Use other distracting techniques.* For instance, one good strategy is to try painting your nails. It may seem silly at first, but when you consider that not only does it distract you from your urge to binge long enough for it to subside, it also keeps your hands busy.
- ♣ *Figure out some distracting strategies for yourself.*

- ♣ Don't forget – urges do pass, and distracters can be just what you need to get rid of the urge (even if only temporarily).
- ♣ Also, don't forget to let yourself have treats. If you restrict yourself to not having any, you will either relent eventually and increase your risk of bingeing, or you will compensate by eating something that you didn't really want in the first place. The idea is to know how much is enough to satisfy without causing too much harm to your emotions and health.
- ♣ Another important technique in helping you to reduce your binge eating is to allow yourself what is known as a "rule-release". This means allowing yourself to be exempt from your scheduled, planned meals in certain situations. These situations may mean allowing yourself to eat a dessert at a social function, or to overeat at a party etc. It is up to you to decide which situations are important enough to release these rules. However, be aware of allowing yourself too many of these instances as they should be the exception, not the rule. Moreover, these should be planned in advance and not used as an excuse to lapse, or as an excuse for a recent lapse.

Group Work; work a schedule in class that may fit someone who is hungry at particular times. Give the group an example to take with them to help them identify the best plan for them.

Example of a plan for one day

(you should work out at least 5 day plans for variety)

Breakfast; 7am

Morning Tea; 10am

Lunch; 12.30pm

Afternoon Tea; 4pm

Tea; 7.30pm

Supper; 10pm

It should be noted that many believe it is not a good idea to eat after 8pm at night. However, if you are more likely to binge in the evening (after 8pm), it is probably a good idea that you schedule a meal or snack during that time.

Breakfast; One orange (this person doesn't like to eat breakfast normally)

Morning Tea; 2 crispbreads with tomatoes on them

Lunch; A salad sandwich, an apple, and a yohurt

Afternoon Tea; A glass of milk and a banana

Tea; Chicken curry and vegetables on rice

Supper; A low-fat chocolate mousse.

Once a plan has been devised of what it is that you are going to eat, you need to work out the proportions of the complex meals (you don't need to work out the grams of a banana for instance!) For this example, 90g of cooked chicken, 3 cups of vegetables (before they are cooked), and 1 ½ cups of cooked rice, would make a filling meal. This meal uses 3

meat servings, 3 vegetable servings and just over 4 grain servings (you can add any herbs and spices you wish).

The whole plan uses;

3 dairy servings (depending on how milk is required for the mousse)

3 meat servings (without meat in the lunch salad sandwich)

4 vegetable servings

3 fruit servings

8 grain servings

Individual work (as homework); work out a meal and snack plan. Keep in mind;

a) Times you are most hungry

b) Times you need more energy than others

c) The optimal food group servings for your needs

d) Don't schedule meals and snacks any less than 2 hours apart, or more than 4 hours apart.

IF YOU DO DECIDE TO ALLOW YOURSELF TO BINGE EAT, THERE ARE USEFUL THINGS YOU CAN DO TO REDUCE THE IMPACT OF YOUR DECISION.

- ♣ Normally, it probably feels like two events when you decide to binge – get the urge and eat.
- ♣ However, there is more to it than that (such as deciding to eat, figuring out what to eat, getting the food (which may even involve a trip to the store), putting the food into your mouth in bite size pieces, chewing, swallowing, getting more food etc.)
- ♣ A very useful way of reducing the impact of a binge episode is to increase the things you do before, during and after you eat.

Lenthening Strategies – adapted from Jenny Craig (emotion management component)

✱ Put this on the overhead

Decide whether to eat (eg. If yes, straighten up the living room before the next step).	Add some of your own in these columns...
Decide what to eat (eg. Then tune the radio to an interesting station. Maybe have a dance around the living room if there's a good song on)	
Remove the chosen food from the fridge or pantry (eg. Place food on the kitchen bench and touch your toes 10 times.)	
Make the food a discrete portion (one that is of an appropriate size for your hunger or wants. Put the rest back in the cupboard knowing you may go back for more). Try	

washing or replacing the container, wash the serving utensils (even if they were already clean!)	
Set a full place at the table (eg. Do a full body stretch)	
Use your utensils to eat, put the utensils down between bites, chew each bite 15 times, pause for a minute half-way through the meal (eg. Pause for 15 seconds between each mouthful. Try anything that will slow your eating down).	
Clear the table (eg. Wash and dry the dishes, wipe the table down).	
Leave the room (if the urge is still strong, repeat the whole process.) If your urge has gone or lessened, use another distracting technique that doesn't involve eating that you have already identified. Fill in your self-monitoring forms and consider how you feel after you've stopped eating.	

Hopefully, the distracting techniques in the brackets will reduce or stop your need to binge. Thus, you may not make it to eating the food before you decide that you really don't want to eat the food. If you do go ahead with eating the food, really focus on how you feel afterwards. If you have managed to put a certain amount of control into your eating (eg., slowing your eating down), you are likely to feel better than if you felt completely out of control. However, you will probably find that you don't feel as good as you might have if you had decided not to eat at all and waited for your next meal.

THIS WEEK'S HOMEWORK

- ✱ To continue monitoring your eating habits – but record only your binge episodes
- ✱ To write an eating plan that makes the best use of the information you have learnt today. Consider scheduling times, specific quantities of food etc. Bring this with you to the next session.
- ✱ Devise 5 other distracting techniques you can use to curb your urge to binge eat. Bring this with you to the next session too.

TABLE OF FEELINGS

(adopted from Bourne, 1995)

POSITIVE EMOTIONS

Accepted	Loving
Affectionate	Loyal
Alive	Passionate
Amused	Peaceful
Beautiful	Playful
Brave	Pleased
Calm	Proud
Capable	Quiet
Caring	Relaxed
Cheerful	Relieved
Cherished	Respected
Comfortable	Safe
Competent	Satisfied
Concerned	Secure
Confident	Self-reliant
Content	Sexy
Courageous	Silly
Curious	Special
Delighted	Strong
Desirable	Supportive
Eager	Sympathetic
Excited	Tender
Forgiving	Thankful
Friendly	Thrilled
Fulfilled	Trusted
Generous	Understanding
Glad	Understood
Good	Unique
Grateful	Valuable
Great	Warm
Happy	Witty
Hopeful	Wonderful
Humorous	Worthwhile
Joyful	Youthful
Lovable	
Loved	

NEGATIVE EMOTIONS

Afraid	Indecisive	Unappreciated
Angry	Inferior	Unattractive
Anxious	Inhibited	Uncertain
Apprehensive	Insecure	Uncomfortable
Ashamed	Irritated	Uneasy
Awkward	Isolated	Unfulfilled
Bitter	Jealous	Used
Bored	Lonely	Useless
Confused	Melancholy	Uptight
Contemptuous	Miserable	Victimised
Defeated	Misunderstood	Violated
Dejected	Muddled	Vulnerable
Dependent	Needy	Weary
Depressed	Old	Wishy-washy
Despairing	Outraged	Worn-out
Desperate	Overwhelmed	Worried
Devastated	Panicky	
Disappointed	Pessimistic	
Discouraged	Phony	
Disgusted	Preoccupied	
Distrustful	Prejudiced	
Embarrassed	Pressured	
Exasperated	Provoked	
Fearful	Regretful	
Foolish	Rejected	
Frantic	Remorseful	
Frustrated	Resentful	
Furious	Sad	
Guilty	Self-conscious	
Hateful	Shy	
Helpless	Sorry	
Horried	Stubborn	
Hostile	Stupid	
Humiliated	Terrified	
Hurt	Threatened	
Ignored	Tired	
Impatient	Touchy	
Inadequate	Trapped	
Incompetent	Troubled	

TABLE OF FEELINGS AND THEIR INTENSITY

(Adopted from Wallis, 1998)

Very Intense

Happiness	Love and Friendship	Sadness	Anger	Fear	Distress
elated	adoring	miserable	fuming	panicky	anguished
giddy	devoted	crushed	outraged	dreading	disgusted
overjoyed	passionate	worthless	furious	horrified	humiliated
radiant	amorous	tormented	incensed	terrified	speechless
ecstatic	tender	depressed	burned up	petrified	sickened
jubilant	ardent	helpless	hateful	desperate	afflicted

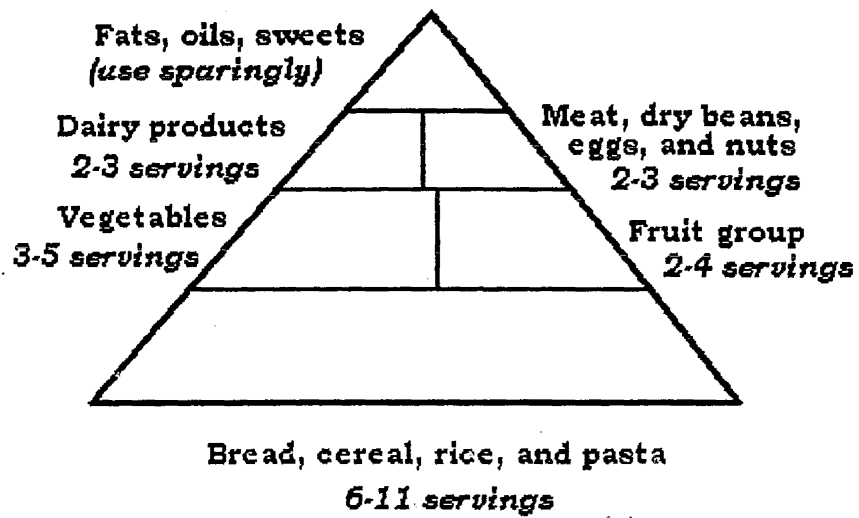
Moderate Intensity

tickled	caring	forlorn	disgusted	alarmed	badgered
glowing	dedicated	burdened	irritated	fearful	bewildered
excited	generous	slighted	aggravated	jittery	confused
joyous	loving	abused	biting	strained	disturbed
bubbly	emphatic	defeated	hostile	shaky	impaired
delighted	considerate	dejected	riled	threatened	offended

Low Intensity

amused	warm	resigned	peevied	uneasy	silly
cheerful	amiable	apathetic	bugged	tense	foolish
pleased	civil	blue	annoyed	timid	unsure
relieved	polite	gloomy	ruffled	anxious	touchy
glad	giving	ignored	nettled	nervous	lost
serene	kindly	glum	cross	shy	disturbed

FOOD GROUP PYRAMID



4 CONSIDERATIONS FOR MEAL PLANNING

1. Times you are most hungry
2. Times you need more energy than others (e.g., during exercise, at work)
3. The optimal food group servings for your needs (see pyramid)
4. Don't schedule meals and snacks any less than 2 hours apart, or more than 4 hours apart.

Lenthening Strategies – adapted from Jenny Craig (emotion management component)

Decide whether to eat (eg. If yes, straighten up the living room before the next step).	Add some of your own in these columns...
Decide what to eat (eg. Then tune the radio to an interesting station. Maybe have a dance around the living room if there's a good song on)	
Remove the chosen food from the fridge or pantry (eg. Place food on the kitchen bench and touch your toes 10 times.)	
Make the food a discrete portion (one that is of an appropriate size for your hunger or wants. Put the rest back in the cupboard knowing you may go back for more). Try washing or replacing the container, wash the serving utensils (even if they were already clean!)	
Set a full place at the table (eg. Do a full body stretch)	
Use your utensils to eat, put the utensils down between bites, chew each bite 15 times, pause for a minute half-way through the meal (eg. Pause for 15 seconds between each mouthful. Try anything that will slow your eating down).	
Clear the table (eg. Wash and dry the dishes, wipe the table down).	
Leave the room (if the urge is still strong, repeat the whole process.) If your urge has gone or lessened, use another distracting technique that doesn't involve eating that you have already identified. Fill in your self-monitoring forms and consider how you feel after you've stopped eating.	

SESSION THREE

HOW EMOTIONS INFLUENCE LIFE IN GENERAL AND EATING PATTERNS/HABITS IN PARTICULAR

* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms, their eating plan, their 5 distracting techniques, and their lengthening strategies form.

Group discussion; did everybody here write an eating plan? Did anyone here actually use it? How did they find it if they did. If they didn't, why not?

Discuss the distracting techniques – get each individual to pick one of the 5 and discuss this with the group. Did anyone use one or more of these techniques, or did they use the lengthening strategy? If so, did the technique or lengthening strategy work? If not, why not? If they didn't try any of these, why not?

This section involves a lot of learning. You can either write it down as we go along, or just listen and a hand out outlining all we've learnt will be given out at the end of this session.

1. What effect do emotions have on eating?

- a. they may stop you from eating; some people have problems eating anything when they are upset
- b. you may eat more; some people eat more when they are distressed.

Group Discussion; Which category do you think you fall into?

Those who have binge eating disorder more often than not fall into the second category.

If you do eat more in response to negative emotions, which ones do you think cause you to eat more?

Can you think of any specific experiences you've had recently that caused you to binge eat?

Write on the board some of the answers the participants came up with.

2. Rationale of the Programme

- Research suggests that binge eating episodes are triggered by emotional distress. That is, people who binge eat often do so in response to feeling negative emotions caused by some problem or situation.
- Research also suggests that those that binge eat may be more overwhelmed by their emotions and less able to cope with them, and less able to recognise the emotions they are feeling.

3. Which negative emotions may trigger eating episodes?

- ♣ Sadness
- ♣ Depression

- ♣ Loneliness
- ♣ Frustration
- ♣ Anger or even rage
- ♣ Anxiety
- ♣ Hate (self-hate for instance)

Other emotions that may trigger binge eating

- ♣ Boredom; sometimes, people eat when they are bored as they can think of nothing else to do and eating helps fill in the time.
- ♣ Happiness; some people eat when they are happy, such as using food “treats” to reward themselves and others.

4. If we just focus on negative emotions for the time being, why do people eat when they are upset?

Group Discussion; suggest some reasons why people eat when they're upset
Why do you eat when you are upset do you think?

Write the following on the board if they miss any.

- a. To help focus their attention on something other than the problem itself
- b. Because it feels good – it gives them comfort and reduces the feelings of depression, anxiety, or any other overwhelming negative emotions
- c. It's become a habit.
 - This may be from learning from their parents – some parents feed their children lollies or other such reinforcing foods to calm them down and this becomes a learnt habit.
 - Otherwise, this may come from years of dealing with their problems this way. In this way, turning to food in difficult situations or during emotional times is a familiar and safe way to deal with the problems.

Group Discussion; Can you relate to any of these reasons for emotional eating?
Can you come up with any other reasons that haven't been mentioned yet?

5. There are negative consequences of using food to make you feel better, to relieve boredom or to celebrate.

Group Discussion; brain storm some reasons why eating may not be a good way to deal with emotional distress, and boredom.

Write these on the board, along with any they have missed.

- You feel overly full and physically uncomfortable after eating too much.
- Eating large amounts of food is unhealthy and can lead to health issues after a long period of time, such as diabetes and heart troubles.

- If you are concerned with your current eating habits and weight, binge eating can make you feel bad emotionally. This has the effect of making you feel out of control of your eating and out of control of your emotions.
- You lose your ability to recognise and distinguish between emotions. This means you may get into a habit of eating in response to emotions generally, and lose your ability to recognise how you are feeling at the time (eg., sad, angry, bored, even happy). This can cause you to lose your ability to deal with emotions effectively.
- The problem is still there and has not been dealt with effectively by eating. That is, the relief from the problem is only temporary.

In addition, eating food may not be a good way to deal with positive emotions. This may be the case due to some of the reasons listed (health issues, current weight problems, negative emotional consequences and loss of ability to distinguish emotions effectively).

Take 5 minutes to write

- How you feel after emotionally eating unplanned food (ie., binge eating)*
- How you feel, or might feel, after resisting the urge to binge.*

Group discussion; consider the above and talk about it in a group setting. Point out that a helpful strategy to resist bingeing is to consider how you will feel immediately after the pleasure of eating leaves. What are you left with, how do you feel when you do? Focus on how negatively you feel after eating before bingeing – if you really consider how you will feel, and you are honest with yourself, you are likely to resist as you realise how bad you feel afterwards. Additionally, how good do you feel when you have resisted the urge to binge? Focus on this before you decide to binge – if you can imagine how you feel when you do resist, this will make resisting easier.

- 6. There are other ways people avoid feeling the intensity of negative emotions, in addition to eating, that are also not very helpful.**

Group Discussion; What are some alternative ways people may express these emotions? Can you think of some other ways that are not eating that people may use to deal with pain and intense negative emotions that are actually counterproductive?

Write these on the board along with any they have missed.

- **Withdrawal**
Some people don't deal with their emotions or the problems that cause these emotions, they just withdraw from the situation causing these emotions. For instance, someone who finds themselves feeling uncomfortable at a social gathering, may leave early or decide not to interact with anyone there (instead, they may sit alone etc.)
- **Avoidance**
Some people simply avoid the situation in the first place if they anticipate that it will cause them to feel negative emotions. For instance, rather than turning up to this social function, the person in the scenario I mentioned before may just choose not to turn up as they thought they may feel uncomfortable if they did decide to go.

- Ignoring the problem
In this case, the problem is already there and the person feeling negative emotions decides not to acknowledge the way they are feeling or the problem that caused them to feel this way. In response, they may use distractions (such as keeping busy, housework, throwing oneself into their work, watching TV, actively choosing to think about something else) to ignore the way they feel.
- Stimulus-seeking or engaging in impulsive behaviour such as shopping, gambling, drinking alcohol etc.
When feeling negative emotions, some people chose to engage in impulsive behaviours to numb the way they feel. This has the effect of using the stimulus to self-soothe, and can be thought of as like taking useless medicine to rid an illness. This method of dealing with negative emotions and problems can be thought of as not only avoiding the problem, but also attempting to ignore the problem.

Binge eating is a type of **psychological numbing** and impulsive behaviour, much like shopping or gambling, that is an attempt to remove oneself from the emotional pain, or even boredom. It is a form of self-soothing behaviour.

7. Psychological Numbing in Depth

A. Although emotional numbing can seem like a helpful thing, and sometimes it can be in the short term, in the long term it can be quite damaging.

B. Numbing, or psychological walls that we erect can separate the person from the pain, but can also remove them from their deepest feelings (Steiner, 1997). Such feelings are not just painful ones, but numbing can also prevent people from feeling love or joy to the extent that it could be felt.

C. Not only that, suppressing emotions can take a lot of energy that could be better used in dealing with them instead.

D. In addition, these walls that people build can come crashing down, leaving the person overwhelmed by the emotions they were numbing themselves from. This happens when the person is under a lot of stress, is distracted, overly tired or exhausted. Stress depletes energy, leaving the person less able to suppress their negative emotions.

E. People who are numb to their emotions are leaving themselves open to being constantly disappointed with their life and the world in which they live (Steiner, 1997).

F. If these people can't tell which emotions they are feeling at the time, how can they tell how strong they are? If they can't tell how strong they are, how can they judge how much these feelings are affecting themselves and other people around them?

Group discussion on these questions. Do they agree that if you can't tell which emotions you are feeling at a certain time, you may not know how strong they are and how they are influencing your life?

BREAK FOR 15 MINUTES

8. What are some situations that may cause negative emotions, which in turn may cause a binge eating episode?

Group Discussion; can you think of any specific situations that have caused you to feel unhappy, angry etc. which may have contributed to a binge eating episode?

- ♣ Social situations; parties, work –do's, going out to dinner with friends
- ♣ Work-related concerns
- ♣ Studying concerns; such as bad results, not passing tests etc.
- ♣ Getting a bad result in other situations; eg. Not passing driver's license
- le. Any situation that compromises your belief in yourself.

9. If they have the potential to cause so much pain and anguish, why do emotions exist? Why do we have emotions and what is their function?

Although all emotions may have different purposes in different situations, we can't argue that they don't exist. They have been proven to exist by scientists and experimenters many times.

In addition, emotions must have a purpose, otherwise they would not feature so frequently and powerfully in our lives.

Group discussion; list possible reasons for emotions

Emotions are a cue to action. They tell us that something needs to be done and that the person feeling the emotion needs to take action. Just like physical pain tells us that something is wrong within our bodies, emotional pain also tells us that something is wrong. Pleasurable or positive emotions act as antidotes to the painful ones, but are also cues to action.

On the most basic level, emotions are a survival tool. One of the most important survival tools people have is the fear response. When something frightens you, your body is primed to action; it is ready for a fight, or for flight. That is, you are ready to stand and fight whatever it is that threatens your survival, or you are ready to run away from it. Many emotions we experience in our daily lives are not this powerful, but some are and these are the ones that require action.

Biological purposes and physiological changes that occur during an emotion
(Adopted from Goleman, 1995)

1. Happiness

- ♥ Gives the body a rest
- ♥ Helps regenerate it after experiencing negative emotions
- ♥ Gives the body readiness and enthusiasm for the next task

- ♥ There are no specific physiological changes to happiness, apart from those in the brain (the chemicals in the brain change so that negative feelings are inhibited and the available energy is increased.)

2. Love

- ♥ Gives the person sexual satisfaction and tender feelings
- ♥ Gives the person a general state of calm and contentment
- ♥ These feelings facilitate cooperation

- ♥ Is known as the “relaxation response” due to its physiological changes
- ♥ And is the physiological opposite of the “fight or flight” response

3. Fear

- The body goes into alert, putting the person on edge and making them ready for action
- The attention is fixated on the threat, which makes the person more able to make the appropriate response

- Blood rushes to the skeletal muscles (eg. The legs), making the “fight or flight” response possible
- The face pales as blood rushes away from it, which creates the feeling that “the blood runs cold”
- The body freezes, if only momentarily, to allow the person time to decide whether hiding is a better idea
- Hormones in the brain are released so that the body goes into alert

4. Surprise

- This emotion allows the person to decide what exactly is going on, and how the best way is to react

- The eyebrows lift during surprise, to allow more information about the unexpected event into the retina

5. Anger

- ❖ Biologically, the purpose of anger is a defense mechanism

- ❖ The blood rushes to the hands, making grasping a weapon easier (hence, many people’s hands shake when they are very angry)

- ❖ The heart rate increases
- ❖ A rush of hormones produces a pulse of energy, which facilitates action

6. Sadness

- ❖ The main reason we feel sad is to help us deal with a significant loss
- ❖ For instance, the death of someone close to us, or a major disappointment
- ❖ The withdrawal into one's self may have encouraged the person to stay closer to home during this time, which would have kept them safe from outside danger.
- ❖ The energy levels drop, and as the sadness approaches depression, it also slows the metabolism.

Introduction to Emotional Intelligence (EQ)

This concept was coined as an equivalent to IQ. In the past, it was often believed that those with high IQ ratings do well in life. However, it has been suggested that EQ is just as, if not more, important in determining our success than IQ. Success does not merely refer to financial success, but also happiness with friendships, family and romantic relationships.

“At best, IQ contributes about 20 percent to the factors that determine life success, which leaves 80 percent to other forces.” (Goleman, 1995, p.34).

Some Definitions

- “Being emotionally intelligent means that you know what emotions you and others have, how strong they are, and what causes them.” (Steiner, 1997, p.12).
- Being emotionally intelligent involves knowing our emotions and being self-aware. It involves recognising our feelings as they occur, as well as being able to manage them effectively (Greenberg & Paivio, 1997)
- “Emotions move us and inform us, and when they are integrated with reason, they make us wiser than we are when we use our intellects alone.” (Greenberg & Paivio, 1997).

Why do we need emotional intelligence?

“People who cannot marshal some control over their emotional life fight inner battles that sabotage their ability for focused work and clear thought.” (Goleman, 1995, p.36).

Ie. People who have mastered their own emotions through emotional recognition and management are better equipped to deal with life, they are more successful generally, and more happy in their life and relationships.

What is emotional intelligence?

(Adopted from Goleman, 1995).

- ⊙ Knowing and recognising your own emotions (self-awareness)
- ⊙ To regulate your moods and keep any emotional distress under control so that it does not inhibit your ability to think and act appropriately (emotional recognition and management).
- ⊙ Being able to resist an emotional impulse, or any other impulse, and delay gratification (emotional management)
- ⊙ Being able to motivate yourself

- ⊙ To read another person's innermost feelings through their emotional expression (facial expression, posture etc.) (Emotional recognition in others).
- ⊙ To empathise and to hope
- ⊙ To be able to handle relationships smoothly (interpersonal intelligence)

The purpose of the next session is to help you to become more emotionally intelligent. We will cover specific emotions, how they look, how they feel, and what effect they may have on our behaviour. We will discuss the physiological changes that happen in each emotion again in more depth in the next session as well, which will help you to recognise your emotions.

THIS WEEK'S HOMEWORK

- ✱ To continue monitoring your eating habits – but record only your binge episodes
- ✱ Write about how you think your emotions affect your life generally, then consider how you think your emotions affect your binge eating problem. You can do this however you like. For instance, you can write full sentences or bullet points, you can write this in columns, or write a page full of brain stormed ideas. You can take as long as you like to do this, keep in mind that the more time you take to think about it, the more you will get out of it.

EMOTIONAL INFLUENCE ON
A: LIFE IN GENERAL
B: EATING PATTERNS AND HABITS IN PARTICULAR

What effect emotions have on eating

- * They may stop you from eating
- * They may make you eat more, especially when you are distressed.

Which emotions trigger eating episodes?

- * Loneliness
- * Frustration
- * Anger or even rage
- * Anxiety
- * Hate (self-hate for instance)
- * Boredom
- * Even happiness

Why eat when you are upset?

- * To help focus your attention on something other than the problem itself
- * Because it feels good (comfort and produces pleasurable physical chemicals)
- * It's a habit

What are the negative consequences of eating in response to emotions?

- * You feel overly full, and physically uncomfortable after eating too much.
- * Eating large amounts of food is unhealthy and can lead to health issues (diabetes, heart troubles)
- * It can make you feel bad emotionally.
- * You lose your ability to recognise and distinguish between emotions.
- * The problem is still there and has not been dealt with effectively. Thus the relief from the problem is only temporary.

Psychological numbing

- * Can be damaging in long term.
- * The psychological walls we erect can separate the person from pain, but can also remove them from their deepest feelings, and love or joy.
- * Suppressing emotions can take a lot of energy. As a result, these walls can come crashing down leaving the person overwhelmed by the emotions they were numbing themselves from.
- * This happens during stress, exhaustion, or when the person is distracted.
- * People who numb their emotions are leaving themselves open to being constantly disappointed with their life and the world in which they live.
- * More to the point, if you can't tell which emotions you are feeling at the time, how can you judge how strong they are? If you can't tell how strong they are, how can you judge how much these feelings are affecting you and other people around you?

Emotional intelligence

- ✱ People who have mastered their own emotions through emotional recognition and management are better equipped to deal with life, they are more successful generally, and more happy in their life and relationships.
- ✱ It is knowing and recognising your own emotions (self-awareness).
- ✱ It is regulating your moods and keeping any emotional distress under control so that it does not inhibit your ability to think and act appropriately (emotional recognition and management).
- ✱ Being able to resist an emotional impulse, or any other impulse, and delay gratification (emotional management)
- ✱ Being able to motivate yourself.
- ✱ Being able to read another person's innermost feelings through their emotional expression (facial, posture etc.)
- ✱ Being able to handle relationships smoothly.

Biological purposes and physiological changes that occur during an emotion

1. Happiness – e.g., gives the body a rest; there are no specific physiological changes.
2. Love – e.g., gives the person a general state of calm; the “relaxation response”
3. Fear – e.g., the body goes into alert, “fight or flight response”; blood rushes, body freezes, face pales.
4. Surprise – allows the person to decide what exactly is going on and how they should best react; the eyebrows lift allowing more information into the retina.
5. Anger – e.g., biologically anger is a defense mechanism; eg., the blood rushes to the hands and heart rate increases.
6. Sadness – e.g., helps us deal with significant loss; energy levels drop and the metabolism slows.

SESSION FOUR

HOW SPECIFIC EMOTIONS FEEL, AND WHICH BEHAVIOURS AND THOUGHTS ARE INVOKED WITH EACH EMOTION

Before we start, it should be noted that this session will concentrate on emotional recognition. However, some people may have no troubles in recognising which emotions they feel, but instead have problems expressing them. We will cover emotional expression briefly in this session, and more extensively in the problem solving section of this programme.

* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms and their page of how their emotions affect their life generally, and their binge eating problem.

SOME INFORMATION ABOUT FEELINGS AND EMOTIONS

(adopted from Bourne, 1995)

What is an emotion?

Group discussion; what do you think an emotion is?

1. Scientists, psychologists and theorists alike have debated this issue for years
 2. The *Oxford English Dictionary* defines an emotion as "any agitation or disturbance of the mind, feeling, passion; any vehement or excited mental state."
 3. Goleman takes the word *emotion* to refer to a feeling and its distinctive thoughts, psychological and biological states, and produces a tendency to act (Goleman, 1995).
 4. Izard, a well known theorist, argues that when you experience an emotion, you can be consciously aware of it without actually thinking about it (Izard, 1971). He argues that an emotion is experienced as a feeling that motivates, organises, and guides perception, thought, and action (Izard, 1991).
 5. A mood tends to last longer and may be more muted than an emotion.
- ◆ Feelings involve a total body reaction. They are mediated by part of the brain and by the involuntary, autonomic nervous system in the body.
 - ◆ Thus, they cause physiological changes in the body and changes in the brain.
 - ◆ It is often argued that there are two types of emotion; basic emotions (which are short-lived and more tied to involuntary physical reactions) and complex emotions (which may be partly shaped by basic emotions, but are also influenced by thoughts and imagery).

- ◆ Feelings are intensified by stress.
- ◆ When we are under stress, our bodies are already in a state of heightened physiological arousal.
- ◆ This heightened arousal is similar to that which comes with an emotion. Thus, as you are already primed to have emotional reactions, it can often take less to provoke an emotion.
- ◆ Feelings are what give you energy when you are in touch with them, and know how to express them. Conversely, if you are unable to express them, you may feel depressed, numb, lethargic or tired.
- ◆ Feelings are often suppressed. This can be a two edged-sword. On the one hand, suppressing emotions and feelings in certain situations can be an advantage to you (eg. Not expressing anger towards your boss can be an advantage to you financially). On the other, if they are never expressed, this can be detrimental to your emotional health. As was mentioned last week, not ever expressing your feelings or emotions can lead to increased difficulty in expressing them generally, or increased difficulty in recognising them.
- ◆ “By acknowledging and managing our feelings and listening to others in a productive way we will enhance rather than diminish our personal power.” (Steiner, 1997, p.12).
- ◆ Feelings are always influenced or caused by something.
- ◆ This something can be our thoughts, or from our perceptions (hearing, sight, smell, touch, taste).
- ◆ There are no right or wrong feelings, but perceptions and experiences that cause them may be misguided. These may be here and now, or past, or memory.
- ◆ Feelings may be appropriate depending on whether the memory, perception, or expectations are accurate.
- ◆ Thus, you can be in a situation, thinking about a possible situation, or remembering a past situation (past, current, or future).

IDENTIFYING YOUR EMOTIONS AND FEELINGS

Group Discussion; what techniques do you use to help you to identify your emotions and feelings? Are there any that you can think of that you don't use but would like to?

- * Nb. Being preoccupied with daily worries etc, or “staying within your head” will have the effect of keeping you out of touch with your feelings.
- * Thus, to begin identifying your emotions, you must switch from inside your head, to focusing on your body.

Here are some useful steps to identifying your emotions (adopted from Gendlin, 1978).

1. Physically Relax

- * It's difficult to know what you are feeling when you are tense

- * Nb. We will be doing a comprehensive section on progressive relaxation that will help you achieve this
- 2. **Ask yourself “what am I feeling now?”**
 - * Focus on your main problem or concern of the moment and see if you can work out which emotion/feeling is attached to this event/problem
- 3. **Tune in to your body**
 - * See if you can find the specific bodily sensations that come with the feeling (eg. Heart racing, sweating etc.)
 - * We will cover some of the physical changes that occur when a specific emotion is evoked in today’s session
- 4. **Wait and listen**
 - * Don’t try to analyse or judge what it is you’re feeling, but just notice that it is there to begin with. Observe yourself, and allow any underlying feelings or moods to surface. If you wait long enough, most often you will find out how you are feeling (and later you can analyse why this may be. The most important part though at this stage is to know what you are feeling and not why.)
 - * Use the list of feelings you have been given to identify specific emotions if you are having problems identifying them without prompting. Soon though, you should learn to identify them without the help of the list.

Group Discussion; make a list of any emotion or feeling you have ever felt or know about but haven’t yet experienced (do this without the help of the list that has been given out).

These can be divided into groups of positive and negative emotions, and into groups of primary and secondary ones. Primary emotions are those which we are born with. Although there is a lot of debate on this topic, it appears that sadness, happiness, fear, surprise, disgust and anger are among those emotions that are innate (or among those we are born with). Secondary ones are those that are learned emotions, and may be learned from our parents and family, from our peers and from society in general.

1. how emotions feel

a. physiologically

Group Discussion; identify which areas of the body tend to change when you feel a strong emotion. Look at the emotions a) happiness; b) love; c) fear; d) anxiety; e) anger; f) sadness; and describe how they feel within the body. Attempt to fill in intensity chart. Did you notice that although they may have similar physiological changes, the way each emotion feels is different from the next?

There are many different areas of the body that change as a result of an emotion or feeling.

1. The heart rate may change
2. Blood pressure may rise or fall
3. The skin temperature can change, you may sweat or your skin may go cold – this is especially evident in the fingers and face
4. Trembling
5. Your breathing may speed up or may slow down
6. And although you don't see it, chemicals in your brain may change.

Review the physiological changes and biological purposes of emotions from last session as a brief reminder.

Group Discussion; how do these emotions feel psychologically (ie. Not within just your body) to you when they occur?

b. psychologically

1. Happiness

- ♥ feels like a warmth, an elation, a joy.
- ♥ Feeling light-hearted and carefree
- ♥ You are likely to feel excited and full of energy,
- ♥ or you may feel just a warm pleasant feeling
- ♥ In it's extreme form, you may feel euphoric or “pumped”

2. Love

- ♥ is somewhat the same, and is likely to be linked with happiness.
- ♥ You may feel excited and full of energy,
- ♥ or feel warm, trusting and secure.
- ♥ You may feel full of self-confidence or invulnerable
- ♥ You may day-dream, be distracted, forget things etc.

3. Fear

- is a response to an actual danger
- This feeling is accompanied by feelings of jitters, or jumpy
- You may feel tense, disoriented, or out of control
- You experience a perceptual narrowing – i.e., time “stands still.”

4. Anxiety

- has a general sense of foreboding or dread of personal doom
- It has an internal meaningfulness to the one experiencing it, such that the individual may feel like they are responding to something that is actually dangerous (even though it's not there).
- The difference between fear and anxiety is that anxiety is provoked in the absence of an external (dangerous) stimulus.
- However, the psychological feelings may strongly resemble those that are invoked by fear

5. Anger

- ❖ May be accompanied by a feeling of irritability, grumpiness, and destructive resentment
- ❖ Depending on the cause of your anger, you may feel empty
- ❖ You may feel out of control if your anger is very intense
- ❖ Feeling angry may prompt you to feel overly emotional
- ❖ Thus, you may feel anxious, tense, or uncomfortable
- ❖ You may also be overly reactive to small irritants. For instance, you may “jump” on someone for saying something only slightly annoying that wouldn’t normally bother you.

6. Sadness

- ❖ Is often associated with feeling run-down, lethargic, tired, or generally low in energy
- ❖ You may feel listless and wish to stay in bed all day
- ❖ You might feel hollow or empty
- ❖ You may have a persistent feeling of wanting to cry
- ❖ The feeling of sadness may also be accompanied by a feelings of irritability, touchiness or grumpiness.

BREAK FOR 15 MINUTES

2. Which events or thoughts may invoke each emotion (just some examples)

Group Discussion; identify which thoughts and events cause you to feel happiness, love, fear, anxiety, anger, and sadness.

1. Happiness

- ♥ An enjoyable or pleasurable experience
- ♥ Thinking about an event that has caused the feelings of happiness

2. Love

- ♥ Seeing a loved one, or spending quality time with them
- ♥ A loved one gives you something you need or desire
- ♥ Thinking about a loved one or time you have spent together
- ♥ Believing that a person loves, needs and/or appreciates you

3. Fear

- Being in a new or unknown situation or place
- Being alone (eg., walking alone in the dark)

4. Anxiety

- Is the same as fear, except it involves a lot of thinking about a fearful event, where as experiencing fear does not involve a lot of thought
- “What-if” thinking
- Feeling uncertain
- Anxiety can be aroused from strong but unexpressed feelings other than anxiety

5. Anger

- ❖ You may feel angry with someone or something
- ❖ You may feel threatened.
 - For instance, you may feel like you are losing power, status, or respect.
 - You may feel threatened through emotional pain
 - Or you may feel threatened through physical pain
- ❖ You may feel angry at losing the opportunity of experiencing something pleasurable (if it is removed, interrupted, or post-poned)
- ❖ If you feel as though you have been treated unfairly you may feel angry
- ❖ Or if you don’t have what you want, or don’t achieve what you want
- ❖ Thinking about someone or something that has previously made you angry is likely to prompt you to feel angry again

6. Sadness

- ❖ Losing something (eg., a friend, an object or possession, a family member). This type of sadness may come from permanently losing something (which would invoke a feeling stronger than sadness known as grief).
- ❖ Thinking about losing something (if you have in the past, if you anticipate it, or just imagine it)
- ❖ Feeling disapproved of or not liked
- ❖ Not being valued by people you care about
- ❖ Believing you are worthless or not valuable
- ❖ Not approving of yourself – anger turned in on yourself can cause sadness
- ❖ Also, quite a few of the events that might cause a person to feel angry may cause someone else to feel sad.

Group discussion; can you think of any events that recently made you feel each of these emotions? Take a piece of paper and briefly describe the event or thought that prompted each emotion (if you don’t think you’ve felt a particular emotion listed here, what do you think would cause you to feel it?)

How did you act when you felt these emotions? How do you think you expressed your emotions on your face?

3. which behaviours are invoked

a. behavioural expression

1. Happiness

- ♥ Jumping around or generally being active

- ♥ Walking with a step
- ♥ Laughing
- ♥ Talking fast/excitedly

2. Love

- ♥ Saying "I love you" or saying positive things to someone you love
- ♥ Sharing experiences or time with someone
- ♥ Doing things the other person wants or needs
- ♥ Holding eye-contact
- ♥ With intimate love, you may touch, pet, hug or cuddle the one you love (that is, physical contact and proximity)

3. Fear

- Talking quickly
- Screaming or yelling
- Or becoming speechless
- Maybe crying
- Running away
- Pleading or crying for help
- Frozen stare

4. Anxiety

- Again is associated with a lot of the same things as fear
- However, this may involve more avoidance from the thing that is causing the anxiety
- Acting jittery (eg., looking around a lot, wringing your hands together, fiddling)

5. Anger

- ❖ Verbally or physically attacking the cause of anger
- ❖ Throwing or breaking things
- ❖ Stomping or walking out
- ❖ Slamming doors
- ❖ Talking or yelling loudly, including screaming or shouting
- ❖ Clenching your hands or fists
- ❖ Making threatening gestures
- ❖ Withdrawing contact with others

6. Sadness

- ❖ Crying is most often associated with intense sadness
- ❖ Eyes dropped towards the ground, looking down and walking with head down
- ❖ A slumped, defeated posture
- ❖ Walking slowly, shuffling
- ❖ Wandering aimlessly
- ❖ Talking quietly or not at all
- ❖ Using a low, slow, monotonous voice
- ❖ Saying sad things or not talking at all (withdrawing from social contact)

b. facial expression

1. Happiness

- ♥ Smiling
- ♥ Wrinkles form at the corners of the eyes
- ♥ Eyes may be partly closed (which is exaggerated in laughing)

2. Love

- ♥ Sometimes the facial expression of love is similar to that of happiness (as it often evokes a feeling of happiness)
- ♥ Or it may involve an intense, concentrating facial expression in more serious moments (not the same as anger though)

3. Fear

- Eyebrows raised and forehead wrinkled
- Eyes wide open, staring and pupils dilate
- Mouth is open and rigid

4. Anxiety

- Much the same as fear (may be less intense in some cases)
- A look of concentration or concern (due to anxious thoughts)

5. Anger

- ❖ Eyebrows are drawn together and down
- ❖ Eyes are open wide and fixated. They may also be reddened with contracted pupils
- ❖ Mouth is usually clenched tightly, with rigid lips and jaw
- ❖ Lips may be tightly compressed or drawn back to expose teeth
- ❖ Nostrils may flare in extreme cases

6. Sadness

- ❖ Forehead may be wrinkled
- ❖ The inner corners of the eyebrows may be drawn down
- ❖ The eyes will be lowered and may be glancing
- ❖ Lips drawn in, corners depressed. The lower lip may be protruded slightly, or it may be tucked between the teeth

4. Examples of psychosomatic symptoms that may be caused by repressing feelings (ie. Physical illnesses that occur as a result of psychological problems).

- ♠ Headaches
- ♠ Ulcers
- ♠ High blood pressure
- ♠ Asthma

- ♠ Stiff tight muscles (eg. Anger or frustration is often accompanied by tight neck and back muscles.)

EMOTION MANAGEMENT;

Group Discussion; what does “managing your emotions” mean to you?

Emotion management does not mean either control or suppression of expression or concealment of emotion from others, especially as the concealed or suppressed emotion still rages inside you (Greenberg et al., 1997)

Nb. Emotion management is a PRACTICED SKILL (like any other) – it involves perceptual accuracy (perceiving the situation or whatever it is that has caused the emotion correctly), emotion recognition skills, and effective management.

Thus, emotion management comes AFTER RECOGNITION.

- ❖ Expressing your feelings does not have to occur immediately if this would be detrimental to your well-being or adjustment. For instance, expressing anger towards your boss may be better suppressed until you are away from your boss (otherwise, you run the risk of losing your job).
- ❖ Emotion management is selecting how expressing emotion and moderating the intensity of the expressed emotion (you are in charge of your emotions and use your emotions to guide a response.)

Emotion management is “the attainment of balanced experience and expression under one’s aware control that is the goal.” (Greenberg et al., 1997).

- ❖ Thus, the emotion is not purely reactive any more, but a response to a situation
- ❖ Moderating and modulating your emotional expression so that it serves *your purposes*.
- ❖ You can learn to use emotional recognition skills not only to manage your emotions, but also to detect the type of problem you are having.
- ❖ Once this has been achieved, you can take action to solve the problem other than binge eating. This may be assertiveness in certain situations, or using more effective problem solving techniques for chronic problems (both of which we will cover in the next couple of weeks).

AN EFFECTIVE TECHNIQUE; EXPRESSING AND COMMUNICATING YOUR EMOTIONS AND FEELINGS

(adopted from Bourne, 1995).

Group Discussion; can you think of useful techniques you have used or would like to use to express an emotion?

1. **Talk it out**

- One of the most helpful ways to express an emotion is to talk about it with a supportive friend or relative
- Talk to someone you trust and to someone who will listen to you (they may not even need to give you advice, as often just talking about a problem or emotion can make you feel better)

2. **Write it out**

- If you are unable to find someone to talk to, write about what you feel freely and without regard to what it is you're writing
- Often the act of writing can help, even if you never read it again
- Some people keep a journal with their emotions in it – very much like a self-monitoring journal except there are no columns and you don't have to write every time you get upset. The journal can help you to identify where your strengths and weaknesses are, and where changes have been made.

3. **Discharge your emotion in other ways that you find helpful**

- Crying when you're sad is one obvious way of expressing this emotion (and anger) but often people don't engage in it. Sometimes, if you feel on the verge of tears but can't make them happen, listening to an evocative piece of music, or watching a sad movie etc. can help.
- Often people don't express anger for fear of hurting others. However, it's possible and often healthy to get rid of residual anger in other ways, particularly as anger can be wrongly displaced (such as taking it out on someone else, which is exactly what you don't want to be doing!)

Eg. Going for a run or some other form of physical exercise

Yelling in a car, or in a deserted bush

Nb. Apart from physical exercise, these other activities are not recommended for daily performance. It has been shown that excessive ventilation of anger can lead to more anger.

- Be assertive. If you are worried about hurting others, but you are putting up with behaviour from others that does not sit well with you, then assertively express how you are feeling

Nb. We will cover assertive training in later sessions

Group Discussion; how do we learn

- a) What emotions are (e.g., family, observation, TV)*
- b) How to express them?*

THIS WEEK'S HOMEWORK

- ✱ To continue monitoring your binge episodes.
- ✱ Try the steps outlined by Gendlin for recognising your emotions (physically relax, ask "what am I feeling now" etc.) Briefly describe whether or not this helped you to recognise your emotions better (bring this to the next session).

- ✱ Attempt to concentrate on your daily emotions. Select one day this week and every time you feel a strong emotion, write it down (refer to your feelings chart). Notice your physical changes in your body (e.g., heart rate, temperature etc.) and how you behave in response to each emotion (you don't have to record your physical and behavioural changes though). Bring your list with you to the next session.
- ✱ Select one of the outlined emotion management techniques and try it during the week (e.g., talk it out – this can be with someone you trust and who will listen to you, or a pet who will not answer back. Sometimes just talking about it to yourself or to an animal can be just as helpful as telling a friend, as just saying it will start to clarify how you feel).

SESSION FIVE

RELAXATION COMPONENT TEACHING EMOTIONAL MANAGEMENT;
INCLUDING ANGER, ANXIETY, STRESS OR SLEEPLESSNESS* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms, the page on Gendlin's emotion recognition technique (did it work for you?), page of daily emotions, and the description on whether or not the emotion management technique actually worked.

Group Discussion; how does stress and tension affect your life at the moment?

Why should relaxation benefit you in emotional management?

Group Discussion; why do you think relaxation is important in emotional management?

- ☞ Relaxation is the opposite to distress. Thus, relaxation inhibits your feelings of distress.
- ☞ It helps you to focus your attention on something other than your emotional distress
- ☞ It quiets you down, allowing you to recognise the emotions you are feeling at the time
- ☞ You are also better able to see why you feel this way (muscle tension is one of the main impediments to awareness of your feelings.)
- ☞ Which makes you better able to manage your emotions.

Relaxation involves many physiological changes;

- ♣ Decrease in heart rate
- ♣ Decrease in respiration rate, which leads to a decrease in oxygen consumption
- ♣ Decrease in blood pressure
- ♣ Decrease in muscle tension
- ♣ Decrease in metabolic rate

It may seem that relaxing when you are distressed is "more easily said than done", relaxation is actually a **learned skill**. And just like any other learned skill, it must be practiced to become useful at stressful times. Learning how to relax is a gradual process that involves regular work and effort on your part.

Today, there are many techniques people can use to help them relax. The technique we are going to cover in this session is called "progressive muscle relaxation", which was first devised by a physiotherapist called Jacobson in 1938. The whole process takes about 20 to 30 minutes. This one was chosen as it can be used anywhere, and at any time, and

doesn't have to take the full 30 minutes to be effective. A well practiced relaxation technique can be used to calm yourself before or after a stressful event, and only takes a few minutes.

The goal of today is to teach you to reduce your level of tension, when you choose to, below your level that you have adapted to in your daily living. The goal of progressive relaxation is to help you to cope with everyday stressful events and emotional distress.

Progressive relaxation involves focusing on particular muscle groups, and then tensing and releasing these muscle groups one by one. The muscle is first tensed as much as it can be without causing pain, and then released all at once. The act of releasing the muscle creates a momentum that allows the muscle tension to drop lower than your level of adaption.

You may be wondering why it is that we first tense the muscles we are going to relax. There are several reasons for this. Firstly, tensing our muscles one by one allows us to focus and become aware of each separate muscle group. This allows us to notice how it actually feels when it is tense. Secondly, every one has a certain level of tension within them during the day. If we spent our day in total relaxation, we may not get anything done, or we would simply fall down! However, quite often our muscles end up more tense than is healthy for daily living. Tensing our muscles allows us to determine exactly how tense they are already. Another reason for tensing the muscles first before relaxing them is it allows you to see the direct contrast between how a tense muscle feels, and how a relaxed muscle feels. Thus, you will be able to appreciate the differences that are associated with these separate states.

Before we begin, we are going to assess your current levels of tension.

- ◆ This will help you to realise how tense you are now
- ◆ After the exercise, we will take another assessment of your tension levels. We will then compare them to the ones before the exercise, and this will help you to see how helpful progressive relaxation is to reducing your levels of tension.

To Begin

Does any one here suffer from chronic pain? If any one here suffers from chronic pain or injury, you can chose not to tense that particular part of your body, or to reduce the tension you apply to it. Again, I would like to emphasis that this is all up to you. The amount of effort you put into this will directly affect how much you benefit. The more you take this exercise seriously, the more you will benefit.

- ☞ If you feel some discomfort during this exercise, move your body to a more comfortable position.
- ☞ If this doesn't work, reduce the amount of tension you are applying. This exercise should not cause physical pain.

- ☞ You may experience feelings of warmth, floatiness, or heavy sensations in your body. This is totally normal, and is what you are aiming to feel.
- ☞ If your mind wanders, just quietly return your mind back to the task.

Problems to be aware of before we start

- ♣ Cramps – these are caused by you holding too much tension. Just release some of the tension so there is no pain.
- ♣ Falling asleep – this can occur when you are this relaxed. However, this is not a good thing when you are learning to relax as it impedes the learning process and your ability to manage your emotions.
- ♣ Muscle spasms and tics – often are a signal that you are falling asleep.
- * Please be sure to release the tension in the muscle immediately, don't let it go gradually or you will lose the effect.
- ❖ Grab your pillows, find a comfortable spot to lie down, and remove anything that will make you uncomfortable (e.g., glasses, bulky jewellery, shoes etc).
- ❖ Close your eyes
- ❖ And remember to keep breathing normally
- ❖ I will help you to become aware of the sensations in your muscles, and show you how to relax the tension.

Group Discussion; From a scale from 1-10, how tense are you at the moment? Write these on the board to compare with after exercise tension level ratings.

1. Become aware of your right arm, especially your right hand.
2. Consider the tension in your hand.
3. Now clench your right hand, tightly, and consider that tension in the hand and how it flows to your forearm.
4. Hold this tension for 10 seconds, and study the sensations in your hand and forearm.
5. Let go of the tension and relax for 15 seconds.
6. Study the feelings of relaxation in your hand and forearm, and compare how relaxation feels to tension.
7. Now become aware of your right bicep, how tense is it at the moment?
8. Clench this muscle, and focus on the tension in your arm (hold this for 10 seconds)
9. Relax this muscle in one go, and compare how this feels to the tension (for 15 seconds)
10. Tense your right shoulder, and hold for 10 seconds. Consider how your shoulder feels when it is tense.
11. Release this muscle and relax for 15 seconds. Consider the difference between how your shoulder feels when it is tense and when it is relaxed.

12. Tense your whole right arm, including your right hand. Stretch your fingers out as far as they will go and hold for 10 seconds. Focus on your whole arm from shoulder to hand and fingers, and consider how it feels when it is tensed.
13. Now release your whole arm at once, and relax for 15 seconds. Compare how your arm, hand, and shoulder feel when they are tense and relaxed.
14. Repeat this whole process with your left hand, forearm, bicep, and shoulder.
15. Consider how your left hand, forearm, bicep, and shoulder feel when they are tensed and relaxed.
16. Now tense your neck muscles, and hold for 15 seconds. Notice how it flows down the top of your back. Focus on the tension.
17. Relax your neck at once, and consider how this feels for 20 seconds.
18. Compare the feeling of tension and relaxation.
19. Tense your torso by holding it in as hard as you can without causing pain. Pull your stomach and chest towards the floor. Hold for 20 seconds and consider how your stomach and chest feel when they are tensed. Notice how the tension in your torso affects your back.
20. Release the tension at once, and relax for 25 seconds. Consider the difference between tension and relaxation in your torso.
21. Tense your bottom as tightly as you can without causing pain. Notice how the tension flows to the backs of your legs (hamstrings). Hold this tension for 15 seconds, and focus on how this feels.
22. Now release the tension and relax the muscles in your bottom. Relax this for 20 seconds. Compare how it feels to be tense and relaxed.
23. Focus on your thighs, and tense them for 15 seconds. Consider how this feels.
24. Relax your thighs at once, and think about how this feels. Compare the tension and relaxation feelings (relax for 20 seconds).
25. Now point your toes and tense your calf muscles and feet. Hold this for 10 seconds and consider how this tension feels in your lower legs and knees.
26. Release the tension and feel your legs relax (hold this for 15 seconds).
27. Now focus on your face and forehead. Because we use our facial muscles so much during the day and tense different areas at different times, we are going to tense this area in small parts. Firstly, tense your forehead until it furrows. Consider how this feels when tensed, and how this feeling probably happens quite often in your day (during concentration etc.) Hold this tension for 10 seconds.
28. Relax your forehead at once and consider how this feels for 15 seconds. Compare the feeling of tension and relaxation in your forehead.
29. Close your eyes very tightly, and tense them for 10 seconds. Feel how your cheeks are also slightly tensed when your eyes are tensed.
30. Release this tension and relax your eyes for 15 seconds. Compare the feelings of tension and relaxation in your eyes.

31. Now tense your mouth in any way that you chose (e.g., in a grimace, in a smile etc), and hold this for 10 seconds. Focus on how this tension spreads over other parts of your face.
32. Let the tension go, and hold for 15 seconds. Compare the feeling of tension and relaxation in your mouth and the other affected parts of your face.
33. Clench your whole face at once and hold for 15 seconds. Think about each part of the face that is tensed.
34. Release the tension at once in your face, and hold this relaxed feeling for 20 seconds and compare this feeling of relaxation to the feeling of tension.
35. Now tense your whole body at once. Tense your hands, forearms, shoulders, neck, torso, legs and feet, and face. Hold this tension as tight as you can without causing pain for 20 seconds. Run your mind over your body, and think about each part and how it relates to the others and how they feel when they are tense.
36. Relax your body in one go and consider how it feels when it is completely relaxed. Let this feeling take over your body and the tension drain out of your body. Compare how this feelings of relaxation feels to the tension you felt before.
37. Stay on the floor for a couple of minutes until you are completely ready to sit up. Don't sit up too fast, just take it slowly.

Group Discussion; Firstly rate how tense you are now from 1-10. Discuss how you feel, and discuss how it compares to feeling tense. Did this exercise help you to relax? Were you able to notice the difference between tension and relaxation?

Another technique you can try is to concentrate on your breathing.

Just become aware of your breathing, don't try to change it, just become aware of it.

- A. Breath in slowly for 7 seconds.
- B. Hold for 3 seconds.
- C. Breath out for 8 seconds.
- D. Repeat this process until you feel your heart slow down and the tension lessen when you are stressed or distressed. Enjoy how it feels to feel relaxed.

Note: your in-breath should be shorter than your out-breath for this to work. If you feel "heady", either stop the exercise or reduce how long you take the in-breath for.

Group Discussion; in what situations do you think you could use this technique? How do you think this could help you to manage your emotions?

THIS WEEK'S HOMEWORK

- ✱ To continue monitoring your binge episodes.
- ✱ Give them a copy of the relaxation technique in detail so that they can practice it at home.

- ✱ Try one of these two techniques during the week, and describe whether or not you felt more relaxed and more equipped to deal with your daily stress (this doesn't need to be an essay! Just use bullet points, brain stormed ideas, or brief sentences to write this description.)

RELAXATION TRAINING – MUSCLE TENSION AND RELAXATION

38. Become aware of your right arm, especially your right hand.
39. Consider the tension in your hand.
40. Now clench your right hand, tightly, and consider that tension in the hand and how it flows to your forearm.
41. Hold this tension for 10 seconds, and study the sensations in your hand and forearm.
42. Let go of the tension and relax for 15 seconds.
43. Study the feelings of relaxation in your hand and forearm, and compare how relaxation feels to tension.

44. Now become aware of your right bicep, how tense is it at the moment?
45. Clench this muscle, and focus on the tension in your arm (hold this for 10 seconds)
46. Relax this muscle in one go, and compare how this feels to the tension (for 15 seconds)
47. Tense your right shoulder, and hold for 10 seconds. Consider how your shoulder feels when it is tense.
48. Release this muscle and relax for 15 seconds. Consider the difference between how your shoulder feels when it is tense and when it is relaxed.

49. Tense your whole right arm, including your right hand. Stretch your fingers out as far as they will go and hold for 10 seconds. Focus on your whole arm from shoulder to hand and fingers, and consider how it feels when it is tensed.
50. Now release your whole arm at once, and relax for 15 seconds. Compare how your arm, hand, and shoulder feel when they are tense and relaxed.

51. Repeat this whole process with your left hand, forearm, bicep, and shoulder.
52. Consider how your left hand, forearm, bicep, and shoulder feel when they are tensed and relaxed.

53. Now tense your neck muscles, and hold for 15 seconds. Notice how it flows down the top of your back. Focus on the tension.
54. Relax your neck at once, and consider how this feels for 20 seconds.
55. Compare the feeling of tension and relaxation.

56. Tense your torso by holding it in as hard as you can without causing pain. Pull your stomach and chest towards the floor. Hold for 20 seconds and consider how your stomach and chest feel when they are tensed. Notice how the tension in your torso affects your back.
57. Release the tension at once, and relax for 25 seconds. Consider the difference between tension and relaxation in your torso.

58. Tense your bottom as tightly as you can without causing pain. Notice how the tension flows to the backs of your legs (hamstrings). Hold this tension for 15 seconds, and focus on how this feels.
59. Now release the tension and relax the muscles in your bottom. Relax this for 20 seconds. Compare how it feels to be tense and relaxed.

60. Focus on your thighs, and tense them for 15 seconds. Consider how this feels.
61. Relax your thighs at once, and think about how this feels. Compare the tension and relaxation feelings (relax for 20 seconds).
62. Now point your toes and tense your calf muscles and feet. Hold this for 10 seconds and consider how this tension feels in your lower legs and knees.
63. Release the tension and feel your legs relax (hold this for 15 seconds).
64. Now focus on your face and forehead. Because we use our facial muscles so much during the day and tense different areas at different times, we are going to tense this area in small parts. Firstly, tense your forehead until it furrows. Consider how this feels when tensed, and how this feeling probably happens quite often in your day (during concentration etc.) Hold this tension for 10 seconds.
65. Relax your forehead at once and consider how this feels for 15 seconds. Compare the feeling of tension and relaxation in your forehead.
66. Close your eyes very tightly, and tense them for 10 seconds. Feel how your cheeks are also slightly tensed when your eyes are tensed.
67. Release this tension and relax your eyes for 15 seconds. Compare the feelings of tension and relaxation in your eyes.
68. Now tense your mouth in any way that you chose (e.g., in a grimace, in a smile etc), and hold this for 10 seconds. Focus on how this tension spreads over other parts of your face.
69. Let the tension go, and hold for 15 seconds. Compare the feeling of tension and relaxation in your mouth and the other affected parts of your face.
70. Clench your whole face at once and hold for 15 seconds. Think about each part of the face that is tensed.
71. Release the tension at once in your face, and hold this relaxed feeling for 20 seconds and compare this feeling of relaxation to the feeling of tension.
72. Now tense your whole body at once. Tense your hands, forearms, shoulders, neck, torso, legs and feet, and face. Hold this tension as tight as you can without causing pain for 20 seconds. Run your mind over your body, and think about each part and how it relates to the others and how they feel when they are tense.
73. Relax your body in one go and consider how it feels when it is completely relaxed. Let this feeling take over your body and the tension drain out of your body. Compare how this feelings of relaxation feels to the tension you felt before.
74. Stay on the floor for a couple of minutes until you are completely ready to sit up. Don't sit up too fast, just take it slowly.

SESSION SIX

RELAXATION SKILLS

- ♣ **This is an extension to the relaxation training you were given in our last session.**
- ♣ **We will start by going over how you found the exercise last week, and whether or not it worked.**
- ♣ **We will then do the exercise again for the first part of this session, so that you can practice it, which will allow relaxation to become a learned skill you can use in every day life. It should be noted that this exercise is just to remind you how to do it, and that to become a learnt skill, you need to practice it in your own time at home.**
- ♣ **We will then cover how you can use relaxation techniques in every day situations to help you with emotion management.**

FIRSTLY

- * I would like you to rate your feelings of tension again (1-10) before we begin (write these on the board)
- * We are going to try a technique that we covered briefly in the last session. This is the breathing exercise, which may be easier to use in certain situations that don't allow the time or privacy for practicing progressive relaxation using muscle tension and release. As we will discuss today, relaxation can be used for any situation where you need to gain control over your emotions to manage the situation effectively.
- * Start by concentrating on your breathing as it is now. Don't change how you are breathing just yet, just focus on it.
- * Now breath in slowly through your nose for 8 seconds, and hold this breath for 4 seconds.
- * Then slowly release this breath through your mouth for 10 seconds.
- * Repeat this exercise about 4 times, or until you feel more relaxed and in control.
- * If you feel slightly "heady", either stop the exercise and resume when your head feels normal again, or reduce how long you take the inbreath for (nb. The in breath should be slightly shorter than the out breath for relaxation to be effective.)
- * Now take your tension ratings again – do they differ from those before we started?

Group Discussion; how did you find this exercise? Did you find that you were more relaxed after the exercise? (Go over the comparisons between their tension rating before and after the exercise).

This breathing regulation exercise is important for emotion regulation skills. When you feel emotionally distressed, your breathing patterns are interfered with. For instance, you may hold your breath, hyperventilate, or breath shallowly. If you concentrate on your breathing, your attention is on the current sensations your breathing has caused, your breathing is regulated, and your mind becomes clear of distractions and repeated thoughts.

REPEAT THE RELAXATION EXERCISE FROM LAST WEEK

Which exercise did you feel was most helpful? Discuss the fact that the muscle tension/release exercise should be practiced just as often as the breathing exercise. It should also be mentioned that the more you practice, the better you become at relaxing. Eventually you can just start the muscle tension/relaxation exercise and your body will respond as if you have already performed the whole thing. Thus, the breathing exercise can be used in stressful situations until the muscle relaxation technique becomes automatic.

To learn the technique effectively, it is a good idea for you to practice about 15-20 minutes per day, until you feel you can relax automatically. It should be practiced in a quiet place, free from distracting noise, and when you have time to spare. If it helps, you can use music to induce relaxation. It can be performed on a chair, in bed, on a couch, on the floor etc.

TAKE A 15 MINUTE BREAK.

DIFFERENTIAL RELAXATION (USING THE RELAXATION TECHNIQUE IN EVERY DAY LIFE).

WITH PARTICULAR REFERENCE TO EMOTIONAL MANAGEMENT

Differential relaxation allows us to get rid of excess tension in our muscles as we go about our normal day performing normal behaviour. It is also a learned skill that follows learning the skill of deep muscle relaxation (the progressive relaxation exercise we did last session and before the break). Differential relaxation is relaxing all the muscles that are not needed to perform the task or to deal with the situation, and only tensing the muscles that are needed to the point of which they can be used without tensing them too much. In other words;

*“(r)elaxing all muscles not essential to the behaviors being performed”
(Spiegler, & Guevremont, 1998).*

For example, if you are about to sit an exam, you will want to relax your face, your neck and back, your legs, and your bottom. You will also want to relax your hands and arms, so the tension doesn't hinder you when you are writing your answers. However, you don't want to relax them so much that you can't write.

Group Discussion; how do you think this technique could be used in every day life?

- A. In situations where you feel anxious or fearful
 - ☞ Before a test or exam
 - ☞ Before a job interview
 - ☞ Before a presentation for something important (work or study)

☞ *Can you think of any other situations that produce anxiety that could be helped by a relaxation exercise?*

B. In situations that make you feel angry

- ☞ When dealing with a difficult customer (they don't even have to know that you are relaxing yourself to help you to effectively cope with their behaviour)
- ☞ When you feel like your rights have been violated
- ☞ When you have missed out on something you really wanted, or you felt you had a right to have
- ☞ When driving (when someone pulls out in front of you, or you are sitting at the lights etc.)
- ☞ *Can you think of any other situations that make you feel angry that could be reduced by using a relaxation technique?*

C. *Can you think of any other strong emotions and stressful situations that could affect your behaviour if you didn't use a relaxation technique first?*

SECONDLY

Having learnt how to deeply relax our muscles using tension, we are now going to relax our muscles without tensing them. Again, this is a learnt skill that comes only with practice.

1. Lie on the floor again, and loosen all tight clothing, remove eyewear etc, and lightly close your eyes.
2. Now concentrate on relaxing your muscles in your body without tensing them.
3. Focus on the most tense muscles, and try to relax them by feeling them sink to the floor (aim to feel how you did when you used progressive relaxation).
4. When you feel you are completely relaxed, scan your body and try to relax it just that little bit more (you may have noticed in our last exercise that muscles you thought were already relaxed were in fact more tense than you'd initially realised.)
5. When you are satisfied that you can't relax any more, commit how this feels to your memory (or keep practicing at home until you know how it feels without effort).
6. Your muscles should have the minimum amount of tension needed to perform your daily activities. However, we adapt to a certain level of tension in our daily lives that may be unhealthy.

In your daily activities, whenever you experience tension in a part of your body that does not need to be tensed for the activities to be performed, take the tension as a signal to relax. Try to relax these muscles, and reduce the tension in the muscles that you are using so that they have the minimum tension required to perform the task. You can do this by breathing techniques, or by the skills you have learnt through practicing progressive relaxation. You may find it helpful to say quieting words to yourself in your head, e.g., "calm", "relax", "let it go" etc. Say this word/ these words at the first sign of tension, before and while you relax your muscles.

Group Discussion; are there any reasons that you can think of that might hinder you from using relaxation techniques before or during stressful situations? Address these and try to come up with solutions.

THIS WEEK'S HOMEWORK

- ✧ To continue monitoring your binge episodes.
- ✧ Briefly describe the relaxation technique you tried during your week (breathing or differential relaxation). Describe the situation on paper, and how you dealt with it after you had performed the relaxation exercise of your choice. Bring the description of your relaxation exercise and stressful situation with you to the next session.
- ✧ Practice the tension-relaxation technique during the week at least 3 times.

SESSION SEVEN

PROBLEM SOLVING SESSION

HOW PROBLEMS INFLUENCE EMOTIONS, AND HOW EMOTIONS AFFECT PROBLEMS

* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms and the description of the relaxation technique they tried. Discuss as a group whether or not they worked for each individual in daily stressful situations.

It should be noted at this point that it is entirely normal for people to experience feelings more intensely when they begin to face situations that they have been avoiding for a long time (Bourne, 1995).

It is hoped that this session will teach you to cope with and manage your emotions, and the problems associated with them.

1. What is coping?

- ☞ People of all ages experience stress and learn to cope with it differently.
- ☞ This learning process occurs from childhood onwards

Group discussion; how do you think we learn to cope with our problems?

- ☞ We learn how to cope with problems from our parents and other relations, from our peers, and from any other influential people in our life (e.g., school teachers).
- ☞ We learn to cope with our problems because emotional and physical distress are very uncomfortable. These feelings of being uncomfortable motivate us to learn to cope with problems.
- ☞ However, sometimes the way in which we've learnt to cope with our problems may be unhelpful, unhealthy, and maladaptive (e.g., binge eating).

Group discussion; define what coping means to you.

- ☞ Coping can be defined as "the process by which people try to *manage (a) perceived discrepancy* between the demands and resources they appraise in a stressful situation." (Sarafino, 1998).
- ☞ Every situation places demands on us. The way in which we evaluate our ability to cope with these demands depends on how we perceive these demands and how many resources we think we have to deal with them.
- ☞ The perceived discrepancy comes from how we perceive the demands, and how we perceive our resources for dealing with these demands.

- ✎ Thus, if we believe the problem to be small, and our resources for dealing with it are large, we will manage this *perceived discrepancy* effectively.
- ✎ However, if we believe the problem to be really big, and that we don't have the resources for dealing with it, we won't manage this *perceived discrepancy* effectively.
- ✎ The word *manage* is essential to problem solving.
- ✎ It indicates that although we are attempting to cope with a problem, our efforts may not necessarily lead to a resolution.
- ✎ Thus managing a problem can be correcting or mastering a problem, but it may also be that the person has learnt to alter their perception of the discrepancy, or accept the harm or threat, or cope by escaping or avoiding the problem.
- ✎ It should be noted that coping is a continuous process. It involves appraisal and reappraisal of the situation, which will involve a re-evaluation of what is happening, what its significance is, and what can be done about it.
- ✎ This re-evaluation process affects any other subsequent coping efforts you make.

2. How problems relate to emotions

Group Discussion; how do you think your daily problems affect your emotions?

How do you think your emotional reactions cause problems?

a. how problems cause emotional responses

- If a situation arises that you find problematic, you will find you have an emotional response to this situation.
- If this situation arises more than once, it becomes a problem.
- Or, if the situation had serious consequences, the consequences become a problem.
- For instance, you are in the office when a colleague comes to you and says something nasty about your appearance.
- If they continue to say horrible things to you on a daily basis, this situation becomes a problem and you will have emotional reactions to it.
- If they only said this to you once, but you couldn't stop thinking about their comment, your thoughts (the consequences of the situation) now become the problem and you will have emotional reactions to it.

b. how emotional responses cause problems

- Your emotional reactions to situations can cause problems.
- Firstly, your emotional reactions, if not dealt with, can influence your life in other ways. Your work, your friendships, your relationships with your family members, your emotional health and psychological well-being can all be affected by strong negative emotional reactions.

- Secondly, as we have discussed previously, emotions that are not dealt with or managed can cause serious physiological problems, such as hypertension etc.
- For instance, if you do not assert yourself to the person in the above situation and attempt to deal with the problem, your emotional reaction will affect other parts of your life. This emotional reaction may become a problem, particularly if you decide to binge eat as a way to deal with these emotions.

3. How to address and deal with problems effectively.

Although problems may seem overwhelming at first, when they are looked at objectively and approached in a systematic way, they become manageable. Approaching certain problems is not by any means an easy task, and will take determination on your part to attempt to solve it rather than avoid it.

A. Emotion-focused coping

- * This is aimed at controlling your emotional response to a stressful situation.
- * This can be done by changing or regulating your behaviour and how you think about the situation.
- * It should be noted that people tend to use emotion-focused coping when they believe they can do nothing about a situation, that they can't change the stressful conditions, or that their resources are not adequate to meet the demands of the stressful situation.

Group Discussion; what actions can you take to regulate your emotions?

There are of-course helpful behavioural strategies we can use to deal with a situation;

- * Use distracting techniques (this can be both helpful and detrimental – depending on the situation)
- * Using alcohol or drugs (always unhelpful in large doses)
- * Engaging in activities such as watching TV or a movie, throwing themselves into work (etc.) (on the whole, this technique is unhelpful).
- * Relaxing (e.g., using the techniques we have already learned, meditation etc.)
- * Seeking emotional support from friends or relatives.
- * Self-control. This can be thought of as attempting to modulate your emotions or actions in relation to the problem.
- * Binge eating is a negative use of emotion-focused coping, and is often used to deal with situations that can in fact be changed. Eating in response to emotions as a way of coping with them can be considered negative because it does not deal with the situation effectively. Instead, the act of binge eating in response to emotional distress often produces more negative consequences (such as feelings of guilt and disgust) rather than dealing effectively with the situation.

Group discussion; What sort of thoughts may be involved in emotion-focused coping?

- * Positive reappraisal – e.g., “I’m sick because I am stressed out. I will use this as an opportunity and a reason to slow myself down a bit.”
- * Denial – e.g., “it didn’t really mean that much to me anyway”
Or “if I pig out today, it won’t matter that much”
- * Denying unpleasant facts – e.g., “that’s not really a lump on my breast, it’s just my imagination.”
Or “I didn’t really eat that much today, I could have eaten so much more if I’d have wanted to.”
- * Changing the meaning of the situation – e.g., “I know the doctor said that if I don’t quit smoking I will die, but everyone has to die of something.”
Or “I know the doctor said if I don’t change my eating habits I will have a heart attack, but people have heart attacks every day even though they’re perfectly healthy.”

Group discussion; do you think these techniques are helpful to dealing effectively with the problem?

Emotion-focused coping can be helpful or detrimental to dealing effectively with a situation.

- ❖ In situations where there really is nothing you can change, emotion-focused coping can be the best way to deal effectively with a situation
- ❖ Examples; stress caused by impending surgery, terminal illness etc.
- ❖ However, in general, there is something that can be done to change a situation.
- ❖ In these cases, emotion-focused coping is not the best way to deal with a situation effectively. Not dealing effectively with a situation, as we have already discussed, can lead to further problems (such as health problems caused by constant stress etc.)
- ❖ There is evidence that emotion-focused coping is the least effective method of coping with life. Avoidant coping methods (a type of emotion-focused coping), for example, have been associated with higher levels of distress.

B. Problem-focused coping

- * Is taking a direct action to solve the problem, or seeking information that will help solve the problem.
- * It is aimed at reducing the demands of the stressful situation, or increasing the resources available to deal with it effectively.
- * Every day includes situations that require problem-focused coping strategies; For instance, getting up on time, getting to work on time, organising meals for the day etc.
- * People tend to use problem-focused coping when they believe their resources match or exceed the demands of the situation.

Think of problem solving as a seven step process. Each problem should be addressed immediately, and individually – don't attempt to address several problems at once, but separate them and deal with them one at a time.

1. Problem recognition

Recognise the problem for what it really is. Remove yourself from the problem, and try to think of it from an outsider's point of view. Acknowledge that there is a problem, instead of denying that one exists.

2. Problem definition

Define the problem in simple terms, e.g., I am angry with my boss. It may not even be necessary to give reasons for the problem, it is just important to know what it is. However, in some situations it may be necessary to know the cause so that you can prevent it from happening again.

3. Brain storming of different solutions

Because this is just a brain storm, it doesn't matter how absurd the solution is, just that you have some alternatives to choose from. Put down those that you adamantly don't want to do – they may be the only viable solution.

4. Evaluation of each solution

Think about whether each solution will really be effective in dealing with that particular problem. Think about ease of use too (it may not be possible to address the problem in that particular way, or when you would like to, so you may have to make plans around small obstacles).

5. Decision making – choose a solution

Choose the best solution for the problem, not the one you would most like to do. Once the problem has been dealt with (however difficult it may have been), you will be very pleased with yourself for not opting out of dealing with it.

6. Implementation of the solution

Now that you have considered all possible options, and you have decided how you are going to approach your problem, implement your solution.

7. Evaluation of the effectiveness of using the solution on the particular problem.

Be honest with yourself. Did your solution really deal with the problem, or are you just taking the easy road out? Taking the easy way is not necessarily the best way to deal with a problem, and may cause more problems in itself than actually deal with the current issue effectively.

Remember; don't give up! If the first choice doesn't work, try another solution. If you can't think of any, ask someone for advice.

Nb. Both problem-focused and emotion-focused coping can be used to deal with one situation.

- *You can use emotion-focused and problem-focused coping when seeking social support. The act of seeking social support can be problem focused if you are trying to seek advice or to acquire some information. It can be emotion-focused if the person is trying to seek emotional support (e.g., getting the person to listen without offering advice).*
- *Or, a person may choose to act in a certain way (emotion-focused coping) that does not help to solve a situation, but then chooses to switch to problem-focused coping (actively attempts to deal with the situation).*
- *Or, a person may choose to control their emotional out-bursts (emotion-focused coping) until they can deal effectively with the situation in a way that will not make the situation worse. For instance, it is best to control an angry out-burst directed towards the boss. This may be achieved by distracting yourself with work until you can think of a problem-focused strategy to deal with the situation. This may involve using assertion to change the situation with your boss.*

TAKE A 15 MINUTE BREAK HERE

Group Work; generate a problem with the class using the problem solving form as an overhead (fill in the spaces as a group). Work together through the seven steps until the problem has been dealt with. Go through several options to solving the problem to show them how one may benefit them, but another may cause additional problems. Ask each participant to offer a solution each, to encourage participation and to note their level of understanding.

4. Emotion and problem regulation writing task

What is it?

- ✿ This is another technique you can use to solve the problems in your life that are causing you emotional distress and your binge eating problems.
- ✿ It involves exploring your thoughts and feelings towards a stressful event through writing, and selecting ways in which you can cope with the situation.

How this will benefit your eating behaviour and emotional regulation;

- ✿ Self-regulation writing has been designed to facilitate your adjustment to stressful events.
- ✿ Rather than just random writing, this technique is designed to help you focus on selecting, enacting, and appraising different ways of coping with these problems (Cameron & Nicholls, 1998).
- ✿ In this way, you be able to make sense of the events that are causing your stress, and enable you to cope with them better.

Group discussion; how many here already write about how you are feeling, how well does this work for you?.

The self-regulation writing task – in steps (the participants will do this now or at home depending on what they prefer as a group)

1. Write for 15 minutes about your deepest thoughts and feelings regarding a recent stressful event that led to a binge episode.
2. Make sure you choose only one specific event.
3. Now list 3 things that you can do to help you to deal with this problem. Select strategies that you can reasonably put into practice.
4. Choose one strategy, and write it down on a slip of paper.

NB. If you are already using writing as a way to express your feelings but it is not helping you to cope effectively with your problems, it may be that you are not writing in a way that allows you to devise possible coping strategies. If you are using writing to devise ways in which you can cope with specific problems, but it is still not working, consider whether or not you are actually putting your best solutions into practice.

Self-regulation writing is another skill that is learnt, and may not come naturally (although some people find it easier than others).

THIS WEEK'S HOMEWORK

- ✱ To continue monitoring your binge episodes.
- ✱ Tonight you are going to take the slip home that describes the best way you can deal with the problem you have written about today, or you are going to perform the whole exercise at home (which will be checked at the beginning of the next session as homework). Over the next week you should attempt to put your solutions into practice. If you find that your strategy is not the most beneficial for dealing with the problem, do the self-regulation writing task again and devise some more strategies. Select a different one and put that into practice.
- ✱ Try the 7-step problem solving exercise. Fill in the form after you have tried it, or during the exercise (whichever is more appropriate for the situation). If you choose to record after you have performed the exercise, do so immediately afterwards to reduce the risk of mistakes in recording due to time lag. Bring this form and any other paper you have used to the next session.

THE PROBLEM SOLVING FORM

1. Problem recognition – describe the problem.
2. Problem definition – define the problem in simple terms.
3. Brain storming of different solutions
4. Evaluation of each solution
5. Decision making – choose a solution
6. Implementation of the solution – think about how you are going to go about implementing your solution to the problem and describe the process here.
7. Evaluation of the effectiveness of using the solution on the particular problem.

SESSION EIGHT

ASSERTION TRAINING

This component is an extension of the problem solving session – assertion training can effectively be thought of as a type of problem solving. This session will teach you ways of relating better socially.

* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms and the problem solving forms. Discuss as a group whether or not they tried their solutions they devised using the self-regulation writing task. Review any new attempts at the self-regulation writing task. If they didn't try the solutions or devise new ones and try those, why not?

ASSERTION TRAINING can be defined as *procedures that attempt to help a person more easily express thoughts, wishes, beliefs, and legitimate feelings of resentment or approval. It teaches and encourages people to speak up and react openly when with others, expressing both positive and negative feelings* (Davidson & Neale, 1998).

Why should we learn to be assertive?

Group Discussion; make a list of reasons why being nonassertive or passive might be unhelpful to your psychological well being and adjustment.

- ✿ Although our society does not seem to value the open expression of feelings and beliefs (eg. "Keep a stiff upperlip" or "He's the strong, silent type."), if we do not express these thoughts and feelings, we often pay a significant emotional price for concealing them.
- ✿ Your wants and needs may not be met if you are not assertive.
- ✿ Poor communication can lead to unsatisfying relationships (particularly romantic ones).

What is being assertive?

Group Discussion; what does being assertive mean to everyone here?

- ✿ In essence, it is about respecting yourself enough to express your beliefs and feelings to others.
- ✿ It means having a basic belief that your opinions, thoughts, values, and feelings are as important as anybody else's.

- * Being assertive also involves becoming self-aware and knowing what you want.
- * To be assertive, you need to believe that you have a right to do so.
- * Learning to be assertive is a way of developing self-respect and self-worth.
- * Assertive rights are basic human rights.
- * Being assertive also means respecting others through being honest and direct without being aggressive in your approach.

Put simply, assertive behaviour involves;

1. *Refusing the requests of others* – ie. Being able to say “no” when others ask you to do something you don’t want to do, especially when the request is unreasonable.
2. *Standing up for your rights* – ie. Being able to object when you think your rights are being violated or when you think someone is cheating you.
3. *Voicing your opinions and feelings* – ie. Being able to express positive or negative ideas or judgements.
4. *Expressing your desires or requests* – ie. Being able to voice your needs or goals to others.

WHAT IS NOT BEING ASSERTIVE?

- A. Being nonassertive or passive
- B. Being aggressive
- C. Being passive-aggressive
- D. Being manipulative

A. What is being nonassertive or passive?

***Group Discussion; what does being nonassertive or passive mean to everyone here?
How do you think being passive differs from being assertive?***

- * Being passive means you don’t respect your own rights to express your ideas, feelings and opinions.
- * It might mean avoiding conflict by saying nothing, even though you disagree.
- * It might mean saying “yes” to something that is unreasonable, or that you don’t want to do.
- * Acting passively also includes feeling guilty – or as if you are imposing – when you attempt to ask someone for something.
- * Those who act passively can be thought of trying to be a “people pleaser”.
- * Being passive differs from being assertive as it involves no action or avoidance action.
- * In the end, being passive may result in you feeling that no-one respects you or that they are taking advantage of you (which they quite possibly could be doing). If you are avoiding something, this may work in the short term, but you will not get what you need or want.

B. What is being aggressive?

Group Discussion; what does being aggressive mean to everyone here? How do you think it differs from being assertive?

- * Aggression involves self-expression which violates the rights of others and demeans them to achieve one's own objectives.
- * It disregards another person's rights to be respected.
- * It is the inconsiderate way of expressing your thoughts and feelings, unlike assertive expression which takes into account the rights of others.
- * Aggression can be thought of as attempting to get what you want *at any cost*.

C. Passive-aggressive communication

Group Discussion; can you guess how this person interacts socially?

- * This means instead of acting assertively, passively or aggressively, you express angry, aggressive feelings in a covert way (in a disguised, almost hidden way)
- * This is done through passive resistance
 - E.g., you're angry at your boss, so instead of confronting them in an assertive manner, you show your contempt by continually turning up late for work
 - E.g., Instead of asking someone to do something, you would continually complain about what is missing (attempting to drop hints in an unhelpful manner).
- * Passive-aggressive people barely ever get what they want as their behaviour leaves other people angry, confused, and resentful.

D. Manipulative

Group Discussion; how do you think people who are manipulative act in social interactions?

- ❖ Manipulative people attempt to get what they want by making others feel sorry for them, or guilty toward them.
- ❖ Instead of taking charge of their own needs, they play the role of the victim in an effort to get others to take care of them.
- ❖ If this doesn't work, the person who uses manipulation will become openly angry, or feign indifference.
- ❖ It should be noted that manipulation only works as long as the person they are manipulating is unaware of this, or is allowing it to happen.

Group Discussion; which method of communication and social interaction do you use (assertiveness, passiveness, aggressiveness, passive-aggressive, or manipulative)? Do you find that your current way of interacting and communicating yields the results you desire? If not, why do you think this is?

Think of one person for each category who fits its description. How do they make you feel when they act this way towards you (this feeling can be positive or negative)?

TAKE A 15 MINUTE BREAK

Self-talk (a brief overview)

Self-talk is your attitudes and beliefs about yourself that are reflected in the words and ideas you use when you “talk” to yourself. Imagine you have a best friend who walks with you every where you go every day and night. Every time you decide to do something, your friend tells you that you can’t do it, and you’d be better off not trying at all. Now imagine this friend is small enough to fit on your shoulder, and goes with you everywhere you go during every day and night. Every time you try to do something, your friend whispers in your ear that you can’t do it and you’d be better off not trying at all. Now imagine this friend is inside your head. No one else knows they’re there, but every time you try to do something, the friend in your head tells you that you can’t do it and you’d be better off not trying at all. If this friend continually tells you that you can’t do anything (or something in particular), despite the fact that you are perfectly capable of doing it, do you think you would try anyway? Your self talk is similar to having a friend inside your head telling you that you can’t do something. The more often you say to yourself you can’t do something, the more likely you are to believe it. However, if you reverse this pattern and tell yourself every time you go to try something new that you can do it, you are more likely to believe it and try.

The type of communication style you use is caused by the type of self-talk you employ. Here is an example that illustrates this point. You are sitting in a group of people, and a discussion begins on race-relations. One person is clearly racist, and you strongly disagree with their point of view. The type of self-talk you use will determine your response and your communication style.

- If you say to yourself, “I might look stupid if I say anything now” or “what if everybody else agrees with this person? If I say something against what that person’s saying, they might attack me” you are likely to use a *non-assertive response*, i.e., do nothing.
- If you say to yourself, “this person is really annoying me, I feel so angry about what they’re saying. How dare they say such things?” you are likely to use an *aggressive response*, i.e., respond angrily towards them.
- If you say to yourself, “no, I disagree with what this person is saying and I have a right to say so” you are likely to use an *assertive response*, i.e., say something that

indicates that you disagree with what they are saying but without becoming extremely emotional.

Clearly, the type of response you give determines the type of response you receive.

- In the non-assertive example, you do nothing and you achieve nothing. The person may continue to say racist things that offend or upset you, but you will feel like you can do nothing about this.
- In the aggressive example, you respond angrily towards the person, and the person will respond in a like mannered way (they are likely to be defensive and attack you verbally or even, in extreme examples, physically).
- In the assertive example, you calmly state that you disagree (and possibly even why you disagree). You may end up debating the issue with the person if you so choose, but they are not likely to act defensively towards you. The end result is that you will feel a great sense of respect for yourself for standing up for your beliefs.

How will learning to be assertive help me with my binge eating problems?

Group Discussion; how do you think assertiveness and binge eating are linked?

- * When you learn about being assertive, you learn to become more aware of your present behaviour in social situations.
- * You can use your newly learnt assertive skills to communicate your feelings and opinions to others (rather than suppressing them).
- * If you feel like others are taking advantage of you, you can use your new skills to act assertively and stop this from happening.
- * If social interactions cause you to feel emotional distress, you can use your new assertion skills to reduce the risk of a negative emotional outcome.
- * This new way of acting will reduce the likelihood that you will feel the urge to binge eat as a result of negative social interactions. This is because acting assertively in social situations is less likely to result in a negative outcome than acting passively or aggressively.
- * Assertive behaviour is often essential if a problem is to be solved in a lasting and constructive way. Unless you use constructive solutions, the problem will continue to affect you.

Today you will learn how to

- a. develop *nonverbal* assertive behaviours
 - b. recognise and being willing to exercise your basic human rights to be assertive
 - c. say “no”
 - d. avoid manipulation
- a. *Developing nonverbal assertive behaviours*

Group Discussion; how do you think you can express assertiveness in ways that do not involve verbal responses?

- * Look directly at another person when you are addressing them, either at their eyes or on their face. If you look down at your feet or away from them will send the message that you are not sure about asking for what you want.

N.B. There is a fine line between being nonverbally assertive and looking at the other person's face when you are addressing them, and staring at them. If you stare at the other person, they are likely to become defensive.

- * Stand with an open posture, not a closed one. For instance, if you are sitting, don't cross your legs, if you are standing, don't fold your arms. Attempting to be assertive with a closed posture is also likely to cause them to become defensive.
- * "Stand your ground", ie. Don't back off or move away while talking to them.
- * Stay calm, don't get too emotional or excited. If you feel angry before attempting to express your thoughts or feelings assertively, then vent your anger somewhere else first.

N.B., a calm but assertive request carries more weight in most situations than an angry outburst.

b. recognising and exercising your basic rights.

Group Discussion; brain storm some ideas for basic human rights.

- * This comes from the *Personal Bill of Rights* (give each participant a photocopy to take home with them)

The Personal Bill of Rights
(adopted from Bourne, 1995).

1. I have the right to ask for what I want.
2. I have the right to say no to requests or demands I can't meet.
3. I have the right to express all of my feelings, positive or negative.
4. I have the right to change my mind.
5. I have the right to make mistakes and to not be perfect.
6. I have the right to follow my own values and standards.
7. I have the right to say no to anything when I feel I am not ready, it is unsafe, or it violates my values.
8. I have the right to determine my own priorities.

9. I have the right <i>not</i> to be responsible for others' behaviours, actions, feelings, or problems.
10. I have the right to expect honesty from others.
11. I have the right to be angry at someone I love.
12. I have the right to be uniquely myself.
13. I have the right to feel scared and say "I'm afraid."
14. I have the right to say "I don't know."
15. I have the right not to give excuses or reasons for my behaviour.
16. I have the right to make decisions based on my feelings.
17. I have the right to my own needs for personal space and time.
18. I have the right to be playful and frivolous.
19. I have the right to be healthier than those around me.
20. I have the right to be in a nonabusive environment.
21. I have the right to make friends and be comfortable around people.
22. I have the right to change and grow.
23. I have the right to have my needs and wants respected by others.
24. I have the right to be treated with dignity and respect.
25. I have the right to be happy.

You also have the right to request something of someone, although you must keep in mind that they, in turn, have the right to say "no" to your request.

c. *learning to say "no"*

Individual work; quickly jot down some situations that you find it hard to say "no" or situations that you feel you can't say it.

Group Discussion; in what situations do you find it difficult to say “no”? In what situations would saying “no” be the most beneficial to you (include ones you feel that you aren’t able to say “no” as yet)?

- * When saying “yes” would conflict with your own needs and desires.
- * When saying “yes” would make you late for something else.
- * When saying “yes” would violate your basic human rights, your moral, beliefs and/or values.
- * When saying “yes” would cause you financial hardship.
- * When saying “yes” would cause you to feel resentment towards the person who is asking for the favour.

What is saying “no”?

- * Saying “no” means that you set *limits* on other people’s demands for your time and energy.
- * It also means being able to say “no” without guilt, and without feeling the need to make excuses.

How it’s done;

1. Acknowledge the other person’s request by repeating it.
2. Explain your reason for declining (this doesn’t mean make excuses, it just means offer a reason).
3. Say no (e.g., “no, thank you” or “no, I’m not interested.”)
Say it in a firm, polite manner.
4. (optional) Where appropriate, offer an alternative proposal where both your own needs and the other person’s needs are met.
*Nb. Only use step four when you can easily see a way of resolving the request equally for both of your needs.

If saying “no” the first time doesn’t work, try repeating yourself calmly and without apologising. If this doesn’t work, try

1. Look the person directly in the eyes
2. Raise the level of your voice slightly
3. Reassert your position (e.g., “I said no thank you.”)

Other tips;

1. *Take your time.* Work out what you are going to say before you respond to someone’s request. You could even make them wait a few days before saying “no” to give you enough time to clarify it in your head.
2. *Don’t overapologise.* When you apologise, you send the message that you are not sure about saying no. This gives the person a “leg in” so to speak, which allows them to attempt to persuade you or put pressure on you to do what you don’t want to do.
3. *Be specific* in what you will and won’t do (be specific with them as well as yourself. Know your boundaries before they ask).

4. *Use assertive body language.* Face the person you are addressing, maintain eye contact, and speak in a calm but firm tone. Avoid getting emotional.
5. *Watch out for guilt.* Guilt may cause you to do something else for that person that you didn't want to do as you feel guilty for saying "no" to their first request.
 - If the person is easily upset by you saying no to them, don't let this interfere with your decision. Instead, change your approach to saying no by saying something like "I don't want you to feel bad, but...". Be sure to make it clear that it is not them you are rejecting, but their request. Also, keep in mind that you are not responsible for the way another person feels, only the way in which you feel.
 - If you are concerned that they will not ask you again if you say no this time, remember that you can only deal with one situation at a time. That is, you can only control here and now, you can't control the future (whether or not they ask again). In addition, it is possible that they may not ask again if you say yes too! Try saying something to the effect of "I'm sorry but it's not possible this time, but ask me again another time". This will express your interest in saying yes in the future, and will make it clear that you are not able to this time.
 - If you are worried that the person will not like you if you say no, consider these two things; (1) is this really true, or are you making incorrect assumptions?
(2) if this really is true, do you really want them as a friend if they can't respect your right to say no?
 - If you feel sorry for the person and this is preventing you from saying no, think about the way in which saying yes, when you should be saying no, makes you feel. You might start resenting them for asking etc., and this may negatively affect your relationship.

Group Discussion; take the situations that you felt you could not say no to before, and as a group, work out some assertive "no" responses for these scenarios.

d. *learning to avoid manipulation.*

On the whole, assertive responses on your part will be received with respect (the person will listen to you and cooperate). However, you might encounter occasions where someone puts off your request or your attempt to say "no".

This is done by simply ignoring or avoiding with dealing with your request. For instance,

- * Changing the subject
- * Responding with a strong display of emotion (including anger or contempt)
- * Joking or making fun of your request
- * Trying to make you feel guilty about your request
- * Criticising or questioning the legitimacy of your request
- * Asking you why you want what you asked for, or why you said no.
- * There are many others *can you think of any?*

Here are some ways that can be used to overcome attempts at avoiding or discounting what you are asking for;

1. *The broken record technique* – simply repeat your request until it is met. This technique is useful with people you do not know or with children (e.g., when returning an item to a retail store.) It is not useful to use the broken record technique in relationships with your spouse or partner, your friends or relatives, or any other intimate relationship.
2. *Fogging* – involves agreeing in part with a criticism. For instance, if you only agree with the principle of the criticism, but not the specific one, you might say “you may be right.” This needs to be done in a calm, quiet voice without defensiveness or sarcasm. Defensive or argumentative responses give the other person something to argue with, while fogging effectively stops communication before the other person can escalate it into a disagreement. Fogging is a good idea when you do not want to listen to criticism and you don’t want to argue. It is not useful in situations where you need to keep communication lines open (e.g. with a spouse.)
3. *Changing the focus* – this is changing the focus of your discussion with someone from the content to a description of what’s going on between you. Essentially, this is a technique that combats the person’s response when they are not hearing you or replying to your request. For instance, they might laugh it off, get angry, or bring up something irrelevant. You can shift the focus back to your request by (1) point out what they are doing (changing the subject or shifting the focus) and (2) bring the focus back to your request by repeating it.
4. *Defusing* – a technique that can be used when someone responds to your assertive request with an angry response or any other extreme emotion. Simply say “I can see that you are upset – let’s discuss this later.” This respects their right to express their strong feelings, and deals with the fact that your request can’t be met while they are doing so.
5. *Assertive enquiry* – is used when someone has attacked you for making the request, and means simply asking someone why they have such a problem with your request.

Note: choose your battles wisely. That is, weigh up the consequences of acting assertively and not acting assertively. Which one produces or would produce the most beneficial consequences for you? Would acting assertively cause more problems than not acting assertively? Be honest with yourself. Don’t avoid acting assertively because it’s seems to be the easiest option, but be aware that sometimes not acting assertively is the best option as the situation doesn’t bother you too much and you predict that acting assertively will be more trouble than it’s worth.

THIS WEEK’S HOMEWORK

- * To continue monitoring your binge episodes.
- * Try one of the assertive techniques
 - a. refusing other’s requests
 - b. standing up for your rights (see the *Personal Bill of Rights*)
 - c. voice your opinions and feelings
 - d. expressing a desire or request

and see how that works for you. Briefly write down your experience using an assertive technique that you normally wouldn't use.

✱ Bring your description to the next session.

The Personal Bill of Rights
(adopted from Bourne, 1995).

1. I have the right to ask for what I want.
2. I have the right to say no to requests or demands I can't meet.
3. I have the right to express all of my feelings, positive or negative.
4. I have the right to change my mind.
5. I have the right to make mistakes and to not be perfect.
6. I have the right to follow my own values and standards.
7. I have the right to say no to anything when I feel I am not ready, it is unsafe, or it violates my values.
8. I have the right to determine my own priorities.
9. I have the right <i>not</i> to be responsible for others' behaviours, actions, feelings, or problems.
10. I have the right to expect honesty from others.
11. I have the right to be angry at someone I love.
12. I have the right to be uniquely myself.
13. I have the right to feel scared and say "I'm afraid."
14. I have the right to say "I don't know."
15. I have the right not to give excuses or reasons for my behaviour.
16. I have the right to make decisions based on my feelings.
17. I have the right to my own needs for personal space and time.
18. I have the right to be playful and frivolous.
19. I have the right to be healthier than those around me.
20. I have the right to be in a nonabusive environment.
21. I have the right to make friends and be comfortable around people.
22. I have the right to change and grow.
23. I have the right to have my needs and wants respected by others.
24. I have the right to be treated with dignity and respect.
25. I have the right to be happy.

SESSION NINE

ASSERTION TRAINING CONCLUDED* REVIEW OF HOMEWORK

- * Check everybody's homework, including self-monitoring forms and the description of the assertive response they used this week. Discuss any problems or successes.

Practice Assertive Responses

Keep in mind that you may already be using assertive responses in some situations, but not others. The ones that you do not use assertive responses in will be the ones that are affecting your psychological well being and adjustment, and your binge eating problems.

Making requests

- many things stop people from making requests
- the things that prevent people from making requests stem from the self-talk they use
 - e.g., "They might say 'no'"
 - "I might feel rejected if they say 'no'"
 - "I might feel like I have failed if they say 'no'"
 - "They might thinking badly of me for asking this of them"
 - "They might think I can't cope on my own if I ask them"
- However, if you don't ask then you definitely won't get what you want or need.

Group Discussion; what reasons do you give yourself for not asking for what you want or need? Can you think of a situation where you haven't asked for something you want or need for some reason? What was the reason that time?

Try considering this before you make up your mind not to ask;

- Again, you definitely won't get what you want or need if you don't ask
- They might say "no" – this is true. Think before you ask how this would make you feel. Consider if the way you will feel is a result of them saying no, or is it a result of the meaning you have attached to a "no" response?
- Be sure to keep it clear in your head that if they say no, it is not you they are rejecting, but your request that they are saying no to.
- If they say "no", will you really have failed or is this just a minor set-back? Redefine your meaning of "failure" to "challenge", and you are more likely to try an alternative method, thereby increasing your chances of success.
- If you worry that they might think you can't cope, keep in mind that all of us have too much to deal with sometimes and have to ask for a little help or guidance to make it through. Those that don't ask for help are less likely to cope, while those who do ask for help are coping simply by asking for help.

- Also, consider how you would feel if they asked you for help as often people feel very happy and privileged to be asked. Even if it is not possible to help them at the time, it can still make you happy that you were asked.

Summary of how to act assertively

1. Describe your problem
 - write a description of that situation.
 - Include *who* is involved,
 - *when* it happened or happens,
 - *what* it is that bothers you,
 - *how* you would normally deal with it,
 - *what* consequences there are of not acting assertively (i.e. why an assertive response would benefit you more),
 - *what fears* you have about the consequences that would follow from acting assertively,
 - and finally, your *behaviour goal*.
 - Be very specific in your descriptions, or you will not fully benefit from this exercise.
2. Evaluate your rights as a human being.
3. Designate a time with the person for discussing what you want that's convenient for both of you. Address the main person involved.
4. State the problem in terms of its consequences for you (give your reasons for saying "no" or for making the request – remember, state reasons and don't make excuses or overapologise.) This has to be done as people are not mind readers, and are more involved with their own problems to consider yours. Even mention bits that seem obvious to you, as they are not necessarily obvious to them, but make sure this is done objectively (without blame or judging).
5. Express your feelings about that particular situation. This allows the person to see how greatly their behaviour affects you, and even if they disagree, they can still understand your point of view.
6. Make your request for changing the situation. Use assertive nonverbal behaviour, keep your request simple, be specific, make requests and not demands or commands. Make only one request at a time, and object to a person's behaviour not their personality (or you will be confronted with defensiveness or anger, and you will not be preserving your respect for the other person).
7. Tell this person the consequences of gaining (or not gaining) his or her cooperation. In loving relationships, this could be a good consequence (e.g., "if you take the dog for a walk, I will give you a back rub.") Sometimes, though, it is not necessary to mention the negative consequences (e.g., "if you don't talk to me we will break up".)

This is because they are obvious, and stating them may come across as a threat (e.g., “if you can’t be ready on time, I’ll leave without you.”)

These techniques can be used for long-term situations, or for “on-the-spot” situations.

Don’t forget to honestly weigh up the consequences of not acting assertively compared to the consequences of acting assertively, and choose your battles wisely.

Individual work; Think about a situation that did not go well for you, and that resulted in you binge eating, or if you can’t remember one, choose a situation that nearly led to a binge, may have led to one in the past, or just made you feel emotionally upset. First describe the situation in detail (describe who was there, where it was etc.), and state how you dealt with it. Consider not whether the response was right or wrong, but whether it achieved the results you wanted. Try to remember what you said to yourself during the event, what self-talk did you use? How did your response affect your feelings, your level of stress, your relationship with the other person etc. Then, go through the steps outlined above, and devise an alternative assertive response.

Group Discussion; was it hard to devise an alternative assertive response? Is the response you have come up with one that you would seriously consider using? If not, why not?

If there is time, the group will pair up and present a quick example each of a situation that would normally make them feel uncomfortable. Each individual will act out an assertive response to a situation that causes them discomfort and that they would not normally act assertively in.

THIS WEEK’S HOMEWORK

- ✱ To continue monitoring your binge episodes.
- ✱ Try a different assertive technique than you used last week and that you would normally use. Briefly describe this on paper and bring this with you to the next session.

SUMMARY OF HOW TO ACT ASSERTIVELY

1. Describe your problem

- Write a description of that situation
- Include *who* is involved
- *When* it happened or happens
- *What* it is that bothers you
- *How* you would normally deal with it
- *What* consequences there are of you not acting assertively (i.e., why an assertive response will benefit you more than not acting assertively)
- *What fears* you have about the consequences that would follow for acting assertively
- And finally, your *behaviour goal*.
- Be very specific in your descriptions, or you will not fully benefit from this exercise.

2. Evaluate your rights as a human being (see the Personal Bill of Rights)

3. Designate a time with the main person involved to discuss what you want.

- Choose a time that's convenient for both of you.

4. State the problem in terms of its consequences for you

- Give your reasons for saying "no", or for making the request
- Remember, state *reasons* and don't make excuses or overapologise.
- This has to be done because people are not mind readers, and are more often than not involved with their own problems than they are with yours.
- Even mention bits that seem obvious to you, as they are not necessarily obvious to them, but make sure this is done objectively (without blame or judging).

5. Express your feelings about that particular situation

- This allows the person to see how greatly their behaviour affects you, and even if they disagree, they can still understand your point of view.

6. Make your request for changing the situation

- Use assertive nonverbal behaviour, keep your request simple, be specific, and make requests not demands.
- Make only one request at a time, and object to a person's behaviour not their personality (or you will be confronted with defensiveness or anger, and you will not be preserving your respect for the other person).

7. Tell this person the consequences of gaining (or not gaining) his or her cooperation

- In loving relationships, this could be a good consequence (e.g., "if you take the dog for a walk, I'll give you a back rub").
- Sometimes, though, it is not necessary to mention the negative consequences (e.g., "if you don't talk to me, we will break up."

SESSION NINE

MAINTENANCE SESSIONS

PART ONE OF TWO: REVIEW OF THE PROGRAMME

A. Problems with understanding throughout the programme.

Group Discussion; are there any particular areas of the programme that you need some help with?

Cover each component separately;

- a. Binge recognition***
- b. Basic nutrition component***
- c. Emotional influence***
- d. Specific emotions***
- e. Relaxation training, and relaxation in everyday life***
- f. Problem solving skills***
- g. Assertion training***

B. Review of the skills learnt in the programme (questions are welcome)

1. Importance of self-monitoring

Group Discussion; how did you find this exercise? Did it help you to identify your binge eating cycles and patterns? Did you learn anything new by monitoring these habits and patterns?

- * Don't forget – you don't need to do this forever. If you have found that your emotional health has improved, and your binge eating has decreased, you may not need to monitor your patterns anymore. Evaluate your reasons for stopping when you do decide to stop.
- * Keep in mind that you may wish to stop monitoring your eating patterns as they have deteriorated, and you don't want to acknowledge it. If this is the case, think about the improvements you have made so far, and how many you want to make now you have the skills. Only you can make yourself face up to your problem.
- * You can always use it again if you feel you are slipping back into old habits. Self-monitoring can not only be used as a tool to identify your patterns, but can also be used to help you get back on track which comes from simply seeing what is happening written down in black and white on a piece of paper in front of you.
- * This is a *skill* you have learnt through this programme that you can use at any time of your life.

2. Binge recognition

Group Discussion; did this session help you to see binge eating in a different way? Did you discover that you were binge eating less, or more, than you had originally thought?

- * It has often been said that knowledge is power. This is true when it comes to identifying your binge patterns, as once you can identify them you can then take steps to control your behaviour.
- * Don't forget that everyone lapses sometimes, don't expect to be perfect.
- * Also, everyone eats more than they think they should sometimes (e.g., at Xmas) – it's how we respond to this that makes the difference.
- * Use the skills you have learnt to deal with these situations.

3. Basic nutrition

Group Discussion; how many of you have changed your eating habits in response to this part of the programme? How many of you have devised an eating plan, and stuck to it? If there is anyone in the group who has planned their meals and snacks and followed through with their plan, how did it affect their binge eating behaviour? Did you find you had more energy throughout the day to do your daily activities? Of those who didn't make a plan, why not? (Take some time to reiterate the benefits of planned meals and snacks, and offer to devise one with them if they feel they can't do it alone).

How many of you used distracting techniques before a binge episode? How did these techniques work for you? If they improved your eating behaviour, discuss this with the group (how you think it worked). If it didn't work, consider as a group other alternatives (keep in mind that it is not the act of attempting to distract yourself from binge eating that doesn't work, it is the specific techniques that are not effective).

4. Emotional influence

Group discussion; was this session helpful to you in recognising how your emotions affect your eating behaviour? Did you find that a specific emotion constantly triggered a binge episode? Were you surprised by this? Were there any emotions that you thought were linked to your binge eating problems, that turned out to be unrelated to them? (Refer to your self-monitoring forms to answer these questions if you haven't thought about this yet).

How did you feel after binge eating? Did you use your self-monitoring forms to help you to see how you felt after an episode? If you look at your filled-in forms now, you will notice that there is a pattern of how you felt after binge eating. Discuss how they felt – are there any similarities between participants? Before you decide to binge, it is a good idea to reflect on how you will feel afterwards. Often, thinking about how you would feel after binge eating is a good motivation to decide not to binge.

Did any of you try the emotion-focused writing technique to deal with an emotionally upsetting event rather than binge eating (other than the one set for homework)? If there is anyone, discuss with them how they felt afterwards when the urge to binge had gone.

- * Emotion-focused writing is another *skill* you have learnt that you can use at any time of your life when you need to. It is not a skill that can easily be unlearned. But to make the most of it, it does need to be practiced.

5. Specific emotions

Group discussion; did you find this session helpful to you to recognising your emotions? How many of you referred to the table during this programme? Of those who did, do you still refer to it? This table can be used at any stage that you need help in identifying how you are feeling, whether you are monitoring your eating patterns or not. You may find you refer to it all the time, you may find you only need it occasionally, or you may find that you can now recognise how you are feeling without the table. I advise you to keep it how ever often you actually use it, just to remind you to be aware of how you are feeling during your daily life.

Did you find any of the emotional management techniques helpful (e.g., talking it out, writing, etc.) Did you find any other techniques of your own helpful in managing your emotions? Discuss these and why they were helpful. If you have not used any of the techniques, why not?

6. Relaxation training

Group discussion; did any of you take this technique home to practice (other than the homework exercise)? If there are any participants who still use it, do you use it at certain times of the day, or only during stressful situations? Of those who don't use this technique, why not?

7. Problem solving skills

Group discussion; did this session help you to manage and cope with your emotions? Did you find that your overall coping style changed from emotion-focused coping to problem-solving coping? If not, are there any situations that you do use some of these techniques you learnt in the problem solving session that you have felt were helpful? Were there any that weren't helpful, or were detrimental, to solving the problem? If you didn't try any problem solving techniques, why not? Discuss specific situations where someone found the problem solving steps were helpful, and compare to one in which they did not find it helpful. Did anyone try a specific solution that did not work, then chose another technique that they identified in the brain storm that did work?

- * Keep in mind that problem solving is also a *learnt skill*.
- * It is not necessarily an easy task to perform, and there will be times where you would rather do nothing than attempt to solve the problem. When this is the case, really think about how this problem is affecting your life (particularly your psychological well-being and adjustment) – do you really wish things to continue as they are? If the answer is “no”, then you really need to take some action! Remember, no one is in charge of your life except YOU!

8. Assertion training

Group discussion; did this training session help you to assert yourself more? Were there any techniques you found most helpful (of the ones offered, e.g., broken record)? Were there any techniques that you found helpful that we did not discuss? Did anyone not try being assertive in situations that required assertive responses? If not, why not? Again, look seriously at the situation and decide whether or not this is negatively affect your life. If it is, do you really want this to continue?

SESSION TWO OF TWO; PLANS

(to help deal with possible threats to each individual's psychological well-being and adjustment).

This whole session is a group discussion on what specific situations you have identified that you are worried are going to cause you set backs in the improvements you have made to your binge eating problems, or that will stop you from improving further. After this session, there are no more sessions, but we will meet again in three months to fill in the questionnaires you filled in before the programme started.

a. Situational variables

Each individual is to identify at least one specific situation that they think will cause some problems with their binge eating.

- (I) Write the situation(s) up on the board.
- (II) Discuss the problems separately, and their meaning to the individual. Is there more than one person who has this problem?

b. Prepared coping responses

- (III) Identify at least one coping response (from either relaxation, assertion, problem solving strategies, or any others that the group suggest) as a group (one suggestion from me and each participant, including the person who has the problem).
- (IV) Evaluate each coping response – what are the possible positive and negative consequences of employing each response? Identify one positive and one negative consequence each. Do this as a group until all possibilities are exhausted.
- (V) Determine whether or not the person thinks they can use any coping response that has been offered. If not, why not? Are there any others that have been missed?
- (VI) At the end, the participant should have a written copy as a reminder that they do not have to put up with it, that they do have a choice to change the situation.

Do this for all the problems that have been identified as possible threats to the improvements they have already made or are about to make to their binge eating problem. Always try to stay one step ahead of the problem. If you find there are other risky situations, identify ways of coping with them *before* they happen.

One last thing

Self-monitoring Forms – how they can be used as a source of motivation

- ✱ Give out each participant a photocopy of all their self-monitoring forms.

- ✱ First of all, we are going to do a writing task that takes 5 minutes. I would like you to write how you felt before you started the programme, and how you feel now that you have completed it.
- ✱ *Group discussion; get each participant to either read their piece of paper, or to explain in their own words how they felt before the programme, and now having completed it.*
- ✱ This piece of paper should be kept in a safe place, along with all the self-monitoring forms from the programme. The reason why this is a good idea, is that these can be used as a form of motivation. Any time you feel like you're slipping back into old habits or old ways of coping with stress and problems, take these forms out and the piece of paper and study them. Think about how you would feel if you let your control of the problem go, and compare this to how you would feel if you kept your control and tried some of the techniques and skills you have learnt doing this programme.

NOW THAT WE HAVE REVISED THE PROGRAMME AND IDENTIFIED SOLUTIONS TO PROMINENT PROBLEMS, could you please fill in the evaluation questionnaire. Once this is done, remind them of the date and time that they will meet for the 3-month follow-up.

A BRIEF LIST TO REMEMBER WHEN YOU FEEL LIKE GIVING IN!

1. Think about all the improvements you have made in the programme, and all the effort you put into it (why give up now when you have come so far!)
2. Start self-monitoring again – really look at what you are eating and whether you are happy with it or not.
3. Remember to eat smaller meals more often – even if you aren't hungry (you may want to binge, not because you are hungry but because you need the energy as you haven't eaten much – food is fuel)
4. Try relaxation – try using the breathing technique, the progressive relaxation one, or the one in which you sink into the floor or chair.
5. Write about how your emotions affect your life generally, and how they affected your binge eating problem. Think also about how much more you are in control of them now you have made all these improvements.
6. To work out what you are feeling try:
 1. Physically relax (you can't tell what you are feeling when you're stressed)
 2. Ask yourself "what am I feeling now?"
 3. Tune into your body (think about your heart rate, are you trembling?, are you sweating?, what's your breathing like?)
 4. Wait and listen (just notice what you are feeling by waiting)
7. Select random days and write your strong emotions down all those days (this will help you practice keeping in touch with them)
8. If you need to manage how you are feeling, try talking about it, writing about it (without regard to what you are writing) etc.
9. If you have a specific problem, ask someone for advice that you can trust and who will be honest with you, or try using the problem solving sheet (you could even ask them to help you with the form if you think it will help)
10. Practice being assertive (try refusing another's request, standing up for your rights (see your personal bill of rights), voicing your opinions, and expressing your desires or requests). The more you practice, the better you will become and the more people will accept the more assertive you (especially if you are consistent). Learn to say no to unreasonable requests, and remember to avoid manipulation (when someone changes the subject, responds with a strong display of emotion, when they joke or make fun of your request etc.) **What are you sacrificing by not being assertive?** Compare this to **what will the consequences be if you do act assertively?** Weight these up – but be honest with yourself. Is this situation negatively affecting your psychological well being and health? Are you binge eating because you're not acting assertively, as a compensation or way of dealing with the negative emotions that come with putting up with the situation?

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APPENDIX 7

SELF-MONITORING FORMS INCLUDING A FILLED-IN EXAMPLE

SELF-MONITORING FORMS

NAME:

DATE:

TIME:

Where were you?	What was going on?	How did you feel?	What did you do to deal with the situation?	What did you eat and drink in response to your emotions?	How did you feel afterwards?	What did you do?

SELF-MONITORING FORMS

NAME:

DATE:

TIME:

<u>Where were you?</u>	<u>What was going on?</u>	<u>How did you feel?</u>	<u>What did you do to deal with the situation?</u>	<u>What did you eat and drink in response to your emotions?</u>	<u>How did you feel afterwards?</u>	<u>What did you do?</u>
At home in the lounge	My partner and I had an argument	Angry and sad at the same time	I went for a walk and bought some food	1 pkt of Ripples salt and vinegar chips (35g) 1 btl of coke (1.5L) 1 pkt of Griffins chocolate chip biscuits	Full and upset with myself. Fat.	Went to my bedroom and watched TV to escape.

APPENDIX 8

SUMMARY DATA

PARTICIPANT WEEKLY BINGE EPISODES

Where W1-10 is week 1-10; B1 and B2 are baseline 1 and 2; P1-P5 is participants 1-5;
G1, G2, and G3 are groups 1, 2, and 3.

Group 1

	P1;G1	P2;G1	P3;G1	P4;G1	P5;G1
W1; B1	9	11	14	1	3
W2; B2	3	8	5	1	3
W3	0	4	12	2	2
W4	0	2	0	0	1
W5	0	1	1	0	2
W6	1	2	2	1	0
W7	0	1	0	0	0
W8	0	1	3	1	0
W9	0	2	0	0	0
W10	0	1	1	0	0

Group 2

	P1;G2	P2;G2	P3;G2	P4;G2
W1; B1	2	3	2	3
W2; B2	1	5	1	1
W3	0	3	1	2
W4	1	0	0	0
W5	0	2	0	0
W6	0	1	0	1
W7	1	0	3	0
W8	0	0	1	1
W9	0	1	1	1
W10	0	0	0	1

Group 3

	P1;G3	P2;G3
W1; B1	16	4
W2; B2	6	5
W3	6	2
W4	0	1
W5	3	0
W6	2	1
W7	0	4
W8	0	0
W9	0	0
W10	0	0

**SUMMARY OF DESCRIPTIVE STATISTICS FOR THE WEEKLY BINGE
FREQUENCIES DURING BASELINE AND INTERVENTION FOR EACH
GROUP**

		Baseline 1	Baseline 2	Week one	Week two	Week three	Week four	Week five	Week six	Week seven	Week eight
Group 1	Mean	7.6	4	4	0.6	0.8	1.2	0.2	1	0.4	0.4
	SD	5.46	2.65	4.69	0.89	0.84	0.84	0.45	1.22	0.89	0.55
	Range	13	7	12	2	2	2	1	3	2	1
Group 2	Mean	2.5	2	1.5	0.5	0.5	0.5	1	0.5	0.75	0.25
	SD	0.58	2	1.29	1	1	1	1.41	0.58	0.5	0.5
	Range	1	4	3	2	2	2	3	1	1	1
Group 3	Mean	10	5.5	4	1.5	1.5	1.5	2	0	0	0
	SD	8.49	0.71	2.83	2.12	0.71	2.12	2.83	0	0	0
	Range	4	1	4	3	1	3	4	0	0	0

SUMMARY OF DESCRIPTIVE STATISTICS FOR THE BES, DASS, PSS, EI, TAS, AND THE COPE.

1. BES

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	30	11.18	12.33	2.66	-0.23
SD	7.07	5.05	7.71		
Range	19	19	24		

2. DASS

Depression

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	17.9	10.81	7.22	0.46	0.29
SD	15.53	12.25	5.99		
Range	42	34	16		

Anxiety

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	10.36	7.27	5.22	0.27	0.24
SD	11.46	8.7	5.29		
Range	36	23	14		

Stress

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	20.73	16.36	13.11	0.3	-0.2
SD	14.67	13.94	8.04		
Range	42	40	26		

3. PSS

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	31.45	26	26.78	0.6	-0.1
SD	9.11	7.84	9.2		
Range	31	22	26		

4. EI

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	113.36	122.45	117.67	-0.47	0.38
SD	19.52	12.44	16.86		
Range	67	38	59		

5. TAS

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	60.9	52.82	49.33	0.67	0.31
SD	12.3	11.36	11.34		
Range	35	30	33		

6. THE COPE***Active Coping***

	Pre-treatment	Post-treatment	Follow-up
Mean	9.27	10.64	10.67
SD	2.61	3.53	4.44
Range	9	11	12

Planning

	Pre-treatment	Post-treatment	Follow-up
Mean	10.66	12.36	10.78
SD	3.41	3.04	3.93
Range	12	8	12

Seeking Social Support

	Pre-treatment	Post-treatment	Follow-up
Mean	9.18	11.36	9.44
SD	3.4	3.64	3.61
Range	11	11	11

Seeking Emotional Support

	Pre-treatment	Post-treatment	Follow-up
Mean	9.9	10.36	9.11
SD	3.33	3.91	3.44
Range	12	12	10

Suppression of Competing Activities

	Pre-treatment	Post-treatment	Follow-up
Mean	8.64	9.73	9.67
SD	2.62	2.65	3.61
Range	10	8	11

Turning to Religion

	Pre-treatment	Post-treatment	Follow-up
Mean	7.82	8.09	7.67
SD	4.05	4.41	3.28
Range	12	12	10

Positive Reinterpretation

	Pre-treatment	Post-treatment	Follow-up
Mean	9.64	11.73	11
SD	3.38	3.88	3.35
Range	11	11	10

Restraint Coping

	Pre-treatment	Post-treatment	Follow-up
Mean	10.27	10	10.44
SD	3	3.74	3.64
Range	10	12	11

Acceptance

	Pre-treatment	Post-treatment	Follow-up
Mean	10.45	11.27	10.44
SD	2.77	2.8	2.3
Range	9	10	7

Venting of Emotions

	Pre-treatment	Post-treatment	Follow-up
Mean	9.82	11.09	9.33
SD	3.03	3.78	2.83
Range	10	12	10

Denial

	Pre-treatment	Post-treatment	Follow-up
Mean	6.82	6.54	6.11
SD	1.89	2.16	2.03
Range	6	7	6

Mental Disengagement

	Pre-treatment	Post-treatment	Follow-up
Mean	9.36	8.54	6.44
SD	3.04	1.97	1.88
Range	10	6	6

Behavioural Disengagement

	Pre-treatment	Post-treatment	Follow-up
Mean	9.91	8	7.78
SD	2.88	2.61	3.23
Range	8	9	11

Use of Alcohol/Drugs

	Pre-treatment	Post-treatment	Follow-up
Mean	5.91	5.63	5.56
SD	4.3	3.88	3.24
Range	12	12	9

Humour

	Pre-treatment	Post-treatment	Follow-up
Mean	9.72	8.64	7.67
SD	3.74	3.07	3.91
Range	12	11	14

Adaptive Coping

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	107.25	120.25	30.58	-0.43	0.59
SD	7.65	9.9	16.21		
Range	22	29	48		

Maladaptive Coping

	Pre-treatment	Post-treatment	Follow-up	Pre to Post Effect Size	Post to F/up Effect Size
Mean	92	87.6	21.13	0.12	0.64
SD	20.52	23.04	9.97		
Range	44	60	32		

SUMMARY OF DESCRIPTIVE STATISTICS FOR THE ATSS DATA

1. USING DAVIDSON AND ASSOCIATES (1983) CATEGORIES

Problem Solving

NEUTRAL

	BEFORE	AFTER
Mean	1.6	1.89
SD	1.35	1.08
Range	5	4
Sum	24	34

EMOTIVE

	BEFORE	AFTER
Mean	2.51	2.36
SD	2.31	1.53
Range	9	5
Sum	113	125

Positive Feeling

NEUTRAL

	BEFORE	AFTER
Mean	4.92	3.78
SD	2.56	2.62
Range	8	7
Sum	64	68

EMOTIVE

	BEFORE	AFTER
Mean	4	3.27
SD	1.88	2.19
Range	5	7
Sum	56	72

Negative Feeling

NEUTRAL

	BEFORE	AFTER
Mean	1.6	1.5
SD	0.7	0.58
Range	2	1
Sum	16	6

EMOTIVE

	BEFORE	AFTER
Mean	6.83	3.21
SD	5.94	3.66
Range	17	15
Sum	123	61

Negative Self-Statement

NEUTRAL

	BEFORE	AFTER
Mean	0	0
SD	0	0
Range	0	0
Sum	0	0

EMOTIVE

	BEFORE	AFTER
Mean	3.25	1.4
SD	2.87	0.89
Range	8	2.24
Sum	26	7

*Neutral Statement**NEUTRAL**EMOTIVE*

	BEFORE	AFTER		BEFORE	AFTER
Mean	2.62	2.06	Mean	3.9	3.37
SD	2.73	1.61	SD	4	2.01
Range	9	5	Range	15	6
Sum	42	33	Sum	82	64

2. USING COPING STYLE CATEGORIES FROM THE COPE*Adaptive**NEUTRAL**EMOTIVE*

	BEFORE	AFTER		BEFORE	AFTER
Mean	1.9	2.38	Mean	2	2.38
SD	1.6	1.04	SD	2.8	1.58
Range	5	4	Range	6	5
Sum	19	31	Sum	54	81

*Maladaptive**NEUTRAL**EMOTIVE*

	BEFORE	AFTER		BEFORE	AFTER
Mean	0	0	Mean	3.93	2.92
SD	0	0	SD	3.22	1.56
Range	0	0	Range	9	5
Sum	0	0	Sum	55	35

APPENDIX 9

CATEGORIES OF IDEA UNITS BY DAVISON AND ASSOCIATES (1983)

Categories of Idea Units for Articulated Thoughts (Davison et al., 1983)

1. **Agree with speaker:** A simple statement of agreement with the speaker's view, with no overt evaluation of the speaker or her behaviour.
2. **Assertive response:** A statement that indicates the person is reacting in an assertive manner to gain positive results to the situation.
3. **Critical evaluation of the self:** A statement that is critical, pejorative, or negative about the self.
4. **Critical evaluation of the referent:** A statement that is critical, pejorative, or negative about the referent of the taped speaker's remarks when the object of the criticism is not the self.
5. **Critical evaluation of the speaker:** A statement that is critical, pejorative, or negative about the speaker(s) on tape.
6. **Critical evaluation of other:** A statement that is critical, pejorative, or negative about some third party other than the direct referent of the speaker's remarks.
7. **Desire to harm:** A statement expressing the wish or intention to physically or psychologically harm the speaker.
8. **Disagree with speaker:** A simple statement of disagreement with the speaker's view, involving no obvious evaluation of the speaker.
9. **Defense of the self:** A statement that specifically serves to defend the self against statements of the speaker or previous statements of the self. These may be an explanation for the behaviour or simply an assertion of its correctness.
10. **Defense of the referent:** A statement that specifically serves to defend the referent against statements of the speaker or previous statements of the self. These may be an explanation for behaviour or simply an assertion of its correctness.
11. **Defense of speaker:** A statement that specifically serves to defend the speaker against statements of the speaker or previous statements of the self. This may be an explanation for behaviour or simply an assertion of its correctness.
12. **Defense of other:** A statement that specifically serves to defend some third party, other than the direct referent of the speaker, against statements of the speaker or previous statements of the self. These may be an explanation for behaviour or simply an assertion of its correctness.

13. **Describe self:** A statement that describes typical or common behaviours, thoughts, attitudes, or feelings of the subject and that is not appropriately placed in any of the other categories.

14. **Empathy with speaker:** A statement that expresses understanding of the speaker's perceptions and feelings or that expresses a familiarity with the speaker's situation.

15. **Positive evaluation of the self:** A statement that is positive or complimentary about the self and that does not specifically serve to defend the self.

16. **Positive evaluation of the referent:** A statement that is positive or complimentary about the referent of the speaker's comments and that does not specifically serve to defend the third party.

17. **Positive evaluation of the speaker:** A statement that is positive or complimentary about the speaker on the tape and that does not specifically serve to defend the speaker.

18. **Positive evaluation of other:** A statement that is positive or complimentary about a third party other than the direct referent of the speaker's remarks and that does not specifically serve to defend the third party.

19. **Positive anticipation:** A statement expressing anticipation of an event that would result in a positive outcome for the self.

20. **Positive feeling:** A statement that expresses a positive affective state of the subject.

21. **Problem solving:** A statement that specifies and/or evaluates a possible course of action or solution to a problem. These solutions or courses of action must be generated by the subject and not by the taped speaker(s).

- A. **Active coping:** taking action, and exerting efforts, to remove or circumvent the stressor.
- B. **Planning:** thinking about how to confront the stressor, planning one's active coping efforts.
- C. **Seeking instrumental social support:** seeking assistance, information, or advice about what to do.
- D. **Seeking emotional social support:** getting sympathy or emotional support from someone.
- E. **Suppression of competing activities:** suppressing one's attention to other activities in which one might engage, in order to concentrate more completely on dealing with the stressor.
- F. **Turning to religion:** increased engagement in religious activities.
- G. **Positive reinterpretation and growth:** making the best of the situation by growing from it, or viewing it in a more favourable light.
- H. **Restraint coping:** coping passively by holding back one's coping attempts until they can be of use.

- I. **Acceptance:** accepting the fact that the stressful event has occurred and is real.
 - J. **Focus on venting of emotions:** an increased awareness of one's emotional distress, and a concomitant tendency to discharge those feelings.
 - K. **Denial:** an attempt to reject the reality of the stressful event.
 - L. **Mental disengagement:** psychological disengagement from the goal with which the stressor is interfering, through day-dreaming, sleep, or self-distraction.
 - M. **Behavioural disengagement:** giving up, or withdrawing effort from, the attempt to attain the goal with which the stressor is interfering.
 - N. **Humor:** Making light of the situation through using humor.
 - O. **Use of relaxation:** A statement that indicates the person speaking is relaxed, or uses relaxation to guide their response to the situation.
22. **Negative anticipation:** A statement expressing anticipation of an event that would result in a negative outcome for the self.
23. **Negative feeling:** A statement that expresses a negative affective state of the subject.
24. **Non-assertive response:** A statement that indicates a response that is in no way assertive, and instead yields to someone else's preferences while discounting the person's own rights and needs.
25. **Other:** Any statement that cannot be placed into one or more of the above categories.
26. **Should:** A statement about a situation, individual, or set of individuals that implies a moral obligation to be or to behave in a particular way, to feel a given way, or to hold a given attitude.
27. **Stress response:** A statement that indicates the person responding to the situation is reacting in a stressed or anxious way to the situation.
28. **Resignation:** A statement that expresses perceived hopelessness or an intention not to attempt to have influence in a situation.

APPENDIX 10

PROGRAMME EVALUATION QUESTIONNAIRES

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?

2. What did you enjoy about the program, and why?
Assertive Training - reinforced beliefs in myself
Group sessions

3. What did you not enjoy about the programme, and why?

4. Did you find the programme helpful?

1 2 3 4 5 6 7

not very much very much

If yes, what parts of the programme did you find of most use?

Assertive Training

Recognizing binge eating

If no, what parts of the programme did you find of little use?

Nutrition - only because I had done it all a year ago.

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

Motivation =

6. What improvements do you think could be made to the programme to help with your binge eating problems?

*Continuous feedback.
Check up every 3-6 mths*

7. Overall, how do you feel having completed the programme?

Good. My life seems to be going well in all aspects.

8. Would you recommend the programme to a friend or family member?

Yes. Even tho it is things you know - it just re-imbres them in your own mind and gets you thinking.

9. Do you have any other comments?

Overall - a great class. Met new people, learnt new skills
- Motivated me + learnt a lot about myself. Courtney was great!!

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 (7)
not very much very much

2. What did you enjoy about the programme, and why?

Meeting new people and talking with them.
seeing that I am not alone even if no one else had the same problem.
being able to acknowledge my shortcomings without guilt.

3. What did you not enjoy about the programme, and why?

Having to write down thoughts and feelings because that meant I had to acknowledge them.

4. Did you find the programme helpful?

1 2 3 4 5 6 7
not very much very much

If yes, what parts of the programme did you find of most use?

the discussion groups

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

I ~~could~~^{can} relate the binge with a happening and hopefully avoid it a next time.
I can accept that sometimes what I thought of as a binge was just needing to eat.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

7. Overall, how do you feel having completed the programme?

Happy I did it, relaxed with my emotions accepting of my failings

8. Would you recommend the programme to a friend or family member?

Most definitely

9. Do you have any other comments?

Good luck Courtney

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 (7)
not very much very much

2. What did you enjoy about the programme, and why?

hearing about myself & relaxing methods
the company

I have been unsure of myself

3. What did you not enjoy about the programme, and why?

4. Did you find the programme helpful?

1 2 3 4 5 6 (7)
not very much very much

If yes, what parts of the programme did you find of most use?

relaxing methods & thinking about having goals
problem solving

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

Winding down the food charts &
problem solving

6. What improvements do you think could be made to the programme to help with your binge eating problems?

7. Overall, how do you feel having completed the programme?

better about myself,

8. Would you recommend the programme to a friend or family member?

I have already

9. Do you have any other comments?

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 ⑦
not very much very much

2. What did you enjoy about the programme, and why?

Getting to know other people
Realising that most people are the same and
have the same issues.

3. What did you not enjoy about the programme, and why?

4. Did you find the programme helpful?

1 2 3 4 5 6 ⑦
not very much very much

If yes, what parts of the programme did you find of most use?

Everything about the programme was great
and I can use all of it at various times.

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

I now feel that I am more control of my life and can deal with the hiccups that occur. It has taught me self help skills.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

Possibly slightly longer because sometimes times its nice just to have time to talk and swap stories. I realize that there are time restraints

7. Overall, how do you feel having completed the programme?

I feel really good and confident. ~~and~~ By using the techniques that I have learnt I feel that most things will become more & more positive. Sometimes I feel empty by not having so need to find something ~~else~~ else to do ~~using~~ the distraction techniques ~~reese~~ help

8. Would you recommend the programme to a friend or family member?

9. Do you have any other comments?

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 (7)
not very much very much

2. What did you enjoy about the programme, and why?

Support - companionship
self discovery learning new skills.

3. What did you not enjoy about the programme, and why?

10 weeks was a big commitment but
the benefits far outweigh any
disadvantages.

4. Did you find the programme helpful?

1 2 3 4 5 (6) 7
not very much very much

If yes, what parts of the programme did you find of most use?

All of it.
The main limitations are the other people
in my life but even recognising that is
significant

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7

not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

Making better choices, eating more regularly
not feeling so negatively about food.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

7. Overall, how do you feel having completed the programme?

Very positive and hopeful I can continue to apply what I have learnt.

Very grateful to Courtney for including me
and being the special person that she is!

8. Would you recommend the programme to a friend or family member?

Yes - have already outlined main points
to a friend.

9. Do you have any other comments?

Please let me know when you are
taking another course so I can tell
my friend.

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?

admitting that I do bring and recognition of
what it is and why I do it

3. What did you not enjoy about the programme, and why?

* as above. it has been very useful but hard to accept, - it isn't the nicest feeling to own up to something with such obvious things.

* things moved a bit slowly sometimes, due to the group I think.

4. Did you find the programme helpful?

1 2 3 4 5 6 7
not very much very much

If yes, what parts of the programme did you find of most use?

as in q)2. As they say, admitting is half way there.

Distracting techniques

If no, what parts of the programme did you find of little use?

Recognition & assertive behaviour.
Things I already do.

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

Recognition of problem. Also helped in
recognition of what triggers my binge
which I would not have thought of
otherwise.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

~~None~~ None. I didn't know what to
expect so I wouldn't know really
what to change.

7. Overall, how do you feel having completed the programme?

Very good. I felt quite bad about
facing the problem at first but now
I find the techniques very useful.

8. Would you recommend the programme to a friend or family member?

yes,

9. Do you have any other comments?

give handout for important bits like homework
Some people find it hard to dictate (not me!).

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?
I enjoyed readdressing some old habits I had formed and needed to change. It was good to get ideas to try and change.

3. What did you not enjoy about the programme, and why?
I think for me it was at a very busy + full time frame of my life. I have not been able to approach and utilize all its tips as I have been too busy. I hope to reinforce the learnt information more so after Christmas / New Year with less pressure on me.

1 2 3 4 5 6 7
not very much very much

Going over strategies to change patterns of eating. Problem solving + assertive training

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

[illegible]

If you feel positive about your eating patterns now, in what way did this programme help?

I feel I can identify them and utilize the techniques I have learnt to divert my bad eating habits.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

Handouts each week to remind me to read up each time at home to reinforce what I have learnt.

7. Overall, how do you feel having completed the programme?

Overall, how do you feel having completed the programme?
I feel I need to practice lots.

8. Would you recommend the programme to a friend or family member?

Yes I would

9. Do you have any other comments?

No.

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?

2. What did you enjoy about the programme, and why?
The interaction with others knowing you're not alone. Being able to talk with the leader of the group.

3. What did you not enjoy about the programme, and why?

3. What did you not enjoy about the programme, and why?
The others in the group frustrated me at times.

4. Did you find the programme helpful?

1 2 3 4 5 6 7
not very much very much

If yes, what parts of the programme did you find of most use?

Binge monitoring forms, What a binge is etc.

Relaxation Techniques

Feelings & Emotions.

If no, what parts of the programme did you find of little use?

For me - the assertiveness as I'm already there.

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

To recognise a binge coming, to derail it
To self talk when required

6. What improvements do you think could be made to the programme to help with your binge eating problems?

None

7. Overall, how do you feel having completed the programme?

Very good, in a positive frame.

8. Would you recommend the programme to a friend or family member?

Yes

9. Do you have any other comments?

That overall really enjoyed learning about binge eating and how to take control of this issue.

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?

Trying to be assertive & it has helped me to understand myself better

3. What did you not enjoy about the programme, and why?

Things stressed me out, when I wasn't sure what I was doing, I felt like giving up. Fortunately, Courtney picked me up when I could easily walked out.

4. Did you find the programme helpful?

1 2 3 4 5 6 7
not very much very much

If yes, what parts of the programme did you find of most use?

Breaking Exercises, I saying no, especially
in the last week, I am not very good
at having regular meals, but I will get there.

If no, what parts of the programme did you find of little use?

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1 2 3 4 5 6 7
not very positive very positive

If you feel positive about your eating patterns now, in what way did this programme help?

In the way it was presented.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

Nothing at all.

7. Overall, how do you feel having completed the programme?

"Great"

8. Would you recommend the programme to a friend or family member?

Yes if I thought they were
having problems

9. Do you have any other comments?

^{nc}
Thanks To Courtney For her time
& Teaching "

If no, what parts of the programme did you find of little use?

None really.

5. Do you feel more positively about your eating patterns, particularly your binge eating?

1
not very positive

2

3

4

5

6

7
very positive

If you feel positive about your eating patterns now, in what way did this programme help?

Made me aware of my down falls

6. What improvements do you think could be made to the programme to help with your binge eating problems?

Maybe more support ~~on the high and low days~~

7. Overall, how do you feel having completed the programme?

Sad, ~~but~~ feel a little bit abandoned, ~~as~~ as ~~it's~~ its the first time ever I've trusted myself enough to really look at my self.

8. Would you recommend the programme to a friend or family member?

yes I would

9. Do you have any other comments?

PROGRAMME EVALUATION QUESTIONNAIRE

1. Have you enjoyed the programme? (please circle a number)

1 2 3 4 5 6 7
not very much very much

2. What did you enjoy about the programme, and why?

The relaxed atmosphere - Safe feeling and the good practical advice because it helped.

3. What did you not enjoy about the programme, and why?

3. What did you not enjoy about the programme, and why? (1)
There was a slight 'rush' feel to the programme!

Little room for error on the programme.

4. Did you find the programme helpful?

1 2 3 4 5 6 7
not very much very much

If yes, what parts of the programme did you find of most use?

Strategies and emotion recognition
problem solving and lots of other
things

If no, what parts of the programme did you find of little use?

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

5. Do you feel more positively about your eating patterns, particularly your binge eating?

[illegible]

If you feel positive about your eating patterns now, in what way did this programme help?

More awareness of what I'm doing with regard to my eating. Has helped me to gain more control over my eating and to use new techniques rather than binge eat.

6. What improvements do you think could be made to the programme to help with your binge eating problems?

7. Overall, how do you feel having completed the programme?

7. Overall, how do you feel having completed the programme?
more confident about how to deal with issues that come up with out turning to feed.
I liked finding out more about how I work. ✓

8. Would you recommend the programme to a friend or family member?

Yes, I would highly recommend
the programme.

9. Do you have any other comments?

NO
Good luck Carthy in the
hot land Australia.